AN ASSESSMENT OF THE POPULATION ACTIVITIES UNDERWAY IN ECUADOR FUNDED BY AID/ECUADOR

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Despite six or more years since the Ecuadorian government formally instituted official family planning efforts at the national level, the total impact on family planning practice is almost inconsequential. The government's own reports claim less than 2 per cent of eligible women as having accepted contraception. A combination of administrative weakness and apathy, if not opposition, in key positions in the official program militated against greater achievements, at least until the change in leadership as recently as May, 1972. Recommendations include: (1) AID should give emphasis to strengthening infrastructure, while continuing to support development of family planning services whenever they appear or seem possible; (2) every effort should be made to institute coordination of public sector efforts in family planning service delivery and information/education activities; (3) in the near future all financing of private sector programs in Ecuador should be turned over to other (non-AID/Ecuador) funding and technical assistance agencies working in the family planning field; (4) emphasis should be placed on a phased concentrated approach of services; and (5) experimental pilot projects should be created.

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INTRODUCTION

In response to a request from the Agency for International Development (AID) Mission in Ecuador, the American Public Health Association (APHA), in conformance with its contract with AID(2604-T01) recruited a team of four individuals with knowledge and experience in population and family planning work in Latin America to "review and evaluate the population activities of AID/Ecuador." The original request generated by the Mission in Ecuador was modified by AID/Washington resulting in a broadening in terms of the scope of the evaluation and review process.

This assignment was interpreted by the APHA to the consultants as follows: "It is proposed that the evaluation team will:

1. develop, jointly with the USAID Mission, a study design to reflect the AID goals, purpose, indicators, inputs, etc.,

2. assess the population/family planning activities and programs in relation to the above; and,

3. report the findings and recommend alternative strategies and activities to increase the effectiveness and viability of the program."

Two members of the consulting team (Dr. Medina and Mr. Blomberg) met in Washington D.C. on July 30th for a briefing with APHA and AID staff on the nature of the assignment. From Washington these two members arrived in Quito on July 31st to begin the field work of the assignment. The Chairman, Dr. Wishik, joined the team August 2nd and the fourth member of the team, Mr. Juan Londono, on August 9th. It was necessary for Dr. Wishik to depart August 13, and Mr. Londono on August 17. Dr. Medina and Mr. Blomberg departed from Quito on August 19.

Due to the breadth of the assignment and the shortness of the time available, the team recognizes that there are shortcomings in the content of the report and that, at best, our understanding of the program lacks a certain degree of depth and appreciation of all the subtleties influencing the development of the program.

General conclusions and recommendations are indicated in a special section of this report. Due to the multifaceted character of the population work in Ecuador, the team has incorporated specific observations and recommendations in the text of the report. These will be found in the final paragraph of each subsection.

* * *

Evaluation can be done against arbitrarily established standards or in relation to stated program goals. The Evaluation Team recognizes the existence of three different sets of objectives held among the relevant parties, as follows:

1.) "AID/Washington" favors emphasis on the goal of prompt fertility reduction to a degree that is significant and that has the momentum to continue incrementally.

2.) "AID/Ecuador" has the same ultimate goal, but emphasizes the importance of the purpose of intermediate strenghening of infrastructure; consequently, fertility reduction would be expected to be less prompt than sought by AID/Washington. The Mission also faces the on-the-spot realities of fitting its efforts to the

Ecuador Government's preferences.

3.) The Government of Ecuador clearly is opposed to fertility reduction as a goal in itself. The National Planning Junta and the Minister of Health have made specific statements opposed to the goal of slowing the population growth rate; they accept Family Planning (FP) for health reasons and insist that FP services always be rendered within a health context. (See Appendix C)

How then, with three rather different frameworks does the Team structure its evaluation of the AID/Ecuador effort? Rather than advancing yet other terms of reference, this report speaks to the ends sought by the three principal parties by addressing the following questions:

a. What is the fertility picture in Ecuador?

b. What are the results obtained by the AID program in strengthening institutions; what impact in FP program development and on fertility have they had thus far? What are the best indicators to assess such results and impact?

c. What is the current climate toward present and proposed AID activities?

d. What does the team believe the next directions and scope of AID activity should be?

We believe this carries out the mandate given to us, while allowing realistically for the complexities of the situation.

In preparation of this report, this team has attempted to assess each of 14 family planning activities in the light of presumed purposes, sometimes stated in Program Agreements (Pro-Ags) or other documents. It has been possible to present appraisals for some of the projects in terms of measured inputs, out-puts and effects. In other instances verifiable indicators are lacking and should be selected, adapted or designed in the process of continuing program operation. Units of measurement and methods of data collection need better definition than now exists.

We recommend that AID/E Mission collaborate with the Evaluation Section of the Department of Population of the Ministry of Health in attempting to develop improved sets of indications to the extent possible.

I. SUMMARY STATEMENT AND PRINCIPAL CONCLUSIONS AND RECOMMENDATIONS

A. SUMMARY STATEMENT

While the task of the team is to report on AID family planning activities in Ecuador it is natural that assessment of these activities tends to place emphasis on program results in the country, implying that such level of results is an indicator of AID's effectiveness as a donor agency. We find it necessary to give our overall impression of the quantity and quality of the Ecuadorian family planning programs and then to try to relate such general assessment to our understanding of the part AID/E played in the picture.

Despite six or more years since the Ecuadorian government formally instituted official family planning efforts at the national level, the total impact on family planning practice in the country can hardly be considered as consequential. The government's own reports claim less than 2 per cent of eligible women as having accepted contraception. Obviously, any decline in fertility rates that may have occured in Ecuador in recent years cannot properly be attributed to a family planning program of such low volume. Some sources report a moderate fall in estimated crude birth rate from about 44/1000 to 38. While the validity of this is open to question, the fact is academic with respect to assessment of the effectiveness of the national FP effort.

Are there obvious explanations for this lack of progress? The team feels that there are and some of these are strongly stated in the report. A combination of administrative weakness and apathy, if not opposition, in key positions in the official program, militated against greater achievements, at least until the change in leadership as recently as May., 1972. We are therefore, in effect, looking at a very new and young program.

Prior to the change, AID/E vested its major efforts in the official relevant agency, the MOH, to little avail. At the same time, it explored for and attempted to capitalize upon readiness and interest in other official and private agencies, insitutions and groups, necessarily in scattered and patchwork fashion. Some of these investments paid off more than others. The combined cumulative effort cannot claim to have attained a cohesive strategy or articulated network that reached an appreciable portion of the geography or population of the country.

This retrospective appraisal should not be construed to impugn the judgements or decisions made at the time. But, as Monday morning quarterbacks, we can easily see that the scoring was not high.

How much basis for optimism may be assumed in the light of recent changes in leadership in the MOH? Do reasonable prospects exist for energetic expansion in FP program objectives and improvement in service delivery? We are not certain on these questions. But we are concerned that the Government's five-year health plan states that its goal for 1977 is to recruit only 4 per cent of eligible women for FP practice. This unambitious objective is in sharp contrast with their high and probably impracticable targets in prenatal and postpartum care and other MCH Services. This even fails to aspire to meet a level of FP demand that might be expected in response to moderate availability of services.

Obviously, implications stemming from these circumstances exist regarding the current AID/E family planning activities and the future directions they might take. Given the firm stand of the MOH concerning the integration of family planning services in the MCH context, wherever they exist in both the public and private sectors, the options for AID/E are, and will continue to remain quite limited. With such constraints, AID/E has little alternative but to continue planning major emphasis on the official agencies as opportunity and strategy warrant, with conservatism appropriate to limited agency goals, but with supportive reaction when increased readiness and interest are manifest.

It is tempting and unavoidable to conjecture on the genesis of the government's strong stand on population and FP. Two artifacts do seem to be present. One is the notorious feeling among Latin Americans that USAID is overly agressive in the population/family planning field. There is no doubt of the presence of some of this element in Ecuador. It is reasonable to believe that the feeling has been exacerbated in reaction to forceful efforts of AID/E to carry out the desires of AID/W. The second moderating factor stems from the attitude that considers FP and MCH antithetical rather than complementary services and from the role of PAHO in crystalizing this as an overt issue plainly exposed to all parties in Ecuador. The plans and efforts of AID/E operate in the very midst of such a difficult climate and must make allowances for it in the future.

B. PRINCIPAL CONCLUSIONS AND RECOMMENDATIONS

We have chosen to open the recommendations section of our report not with a recommendation but rather a consideration regarding the nature of the present arrangement for U.S. financing of the Ecuadorian population effort. It is a consideration because the team is not in a position to recommend a specific alternative with the assurance that it is both feasible and acceptable.

In any case, we beleive it would be desirable and wise to move from the current status of bilateral funding of program to one which is multinational and/or multilateral, including non-governmental donor agencies. We hold this belief for several reasons, among them, the following:

1. There is a potential for political tension between the U.S. and Ecuadorian governments on matters unrelated to the population program but which might eventually have repercussions on it. An example is the Foreign Aid bill recently passed by the U.S. Congress which specified response policy toward Ecuador and Peru regarding the capture of American fishing vessels. We Believe that decisions about the population program in Ecuador, from the point of view of the Ecuadorian Government as well as that of the U.S. government, may be influenced by the quality of these bi-national relations, with the possibility that the decisions taken will be detrimental to the continuation and successful development of Ecuador's family planning program.

2. As in other countries throughout Latin America, there are groups in Ecuador from both the extreme right and left who attack family planning as an imperialistic plot of the U.S. to subjugate the developing world. (See Appendix D - The Cuenca Statement) We believe that the current direct bilateral financing of Ecuador's Family Planning work through the AID/Ecuador mission has the potential for contributing unnecessary credibility to the position being taken by these opponents. We recognize that idealogues will promote these attacks regardless of the channels of program funding, but we feel that the present arrangement does not minimize the strength of these attacks, particularly if the details of the intimacy of U.S. in-

volvement and relation to the program were to come into possession of these opponents. A multilateral funding arrangement has the potential for deflecting and nullifying the authenticity of these opposition arguments. As our report evidences, we are hopeful and to a degree optomistic about the prospects for notable improvements in the Ecuadorian family planning effort in the coming years and because of this we are anxious to assure it the most propitious circumstances for its expansion.

While the team would favor a shift on funding arrangements to a multilateral and/or multinational basis, we acknowledge that, if such a policy were adopted by AID/Washington, it would, of necessity, have to be a phased and gradual shift as the mechanisms and agencies for supporting the program are identified. Further it may be found advisable to treat public and private programs differently with respect to this issue.

In recognition of the fact that bilateral funding will undoubtedly be continued for at least some interim period, if not permanently, we offer in continuation our general recommendations for improving the quality of AID's population work in Ecuador.

Recommendation No. 1: Institution Building vs. Direct FP Program Support

Because of infrastructure weaknesses and unfavorable climate, AID Ecuador does not have an unlimited range of FP programs to recommend or support. For the present, therefore, AID must give emphasis to strengthening infrastructure, while continuing to support development of FP services whenever they appear or seem possible, and while continuing to work for elevation of readiness among official, professional and other influential persons and in the public at large.

Commentary

a. The Government's strong policy on integration of FP services in the health program prevents the continuation or expansion of free standing FP services, which in many respects would have called for a simpler infrastructure, but would require a more intensive supervision network. The policy also limits extensive mass media approaches to the public.

b. Effective FP service to rural populations necessitates use of resident lower level personnel (warranted workers), a practice which depends in part on the willingness of the medical profession to delegate responsibility. The medical profession of Ecuador is not ready for such changes. Education of the physicians is necessary; it helps them to become proficient enough to FP work and to be more tolerant toward, and cooperative with, transfer of certain functions. AID mission has attempted to further such progress through its support of seminars and training and through involvement of professional personnel in the various clinical projects. Continued formal efforts to reach the 2,000 physicians of the country should be continued.

c. The administrative structure of Public Health in Ecuador is weak. Although the Population Department in the MOH has a larger staff than comparable departments, few incumbents other than the head are qualified or very effective. For such key positions, short seminars do not constitute adequate preparation. Several persons should be sent abroad for a year of didactic training and supervized practical experience in a field placement (in Spanish).

Trainees should be carefully selected on the basis of qualification for University

admission and commitment by them and the MOH. For most of them, the emphasis should be on administration and for at least one on the acquisition of competence in training methods.

The administrative structure of the MOH is ambiguous as to: staff and line functions from headquarters to the provinces and local area; vertical relations above and below the Population Department; and horizontal ties between the sections of the Population Department.

Except for the anti-malaria program and possibly certain other special services, supervision has been weak or absent until recently, when four FP supervisors were appointed. However, except for the supervisor in Manabi, their territories are too large; in all the zones the ratio of supervisors to locations and to field personnel is too low, their duties are not well defined and their training in FP is negligible. In response to requests from Dr. Corral, the Director of the Population Department, the Evaluation Section is proceeding to furnish the supervisors with indicators for ranking clinics and personnel and with guidelines for priorities and clues for selective supervision. The Section should give urgent attention to this. It would be preferable if the areas assigned to each supervisor were considerably reduced and evaluative data collected to determine the best patterns of supervisory structure and work that should be generalized.

In addition, the supervisors are carrying certain inappropriate administrative duties, such as distribution of supplies, that prevent their devoting full attention to supervision.

d. It is difficult to know how to obtain sufficient time and interest of the physicians and other health center personnel in FP work. The physicians consider themselves underpaid and tend to spend less than the contracted amounts of time. They naturally resent new FP duties that would require more of their time, even though still within the number of hours for which they are being paid.

It would not seem proper to pay additionally per unit of FP work done during regular work hours, although this is practiced in some countries. That would tempt health personnel to give less emphasis to other types of work. An alternative approach would be to pay for additional work done at other time than the usual clinic hours, although this would be costly and introduce administrative problems.

For the present, MOH is merely introducing FP duties and expecting these to be absorbed without additional recompense. A study by the Evaluation Unit suggests that most of the physicians fall short of achieving a reasonable target of work volume.

The dilemma is a serious one. It is hard to believe that discipline alone can result in change of medical attitudes and practices. The matter warrants careful monitoring and possible experimentation with different incentives, whether financial or through other awards, such as training fellowships.

These are illustrations of need for strengthening the administrative context in which the MOH's FP services operate. These conditions are not easily within AID's ability to change. But the FP program in Ecuador is not likely to prosper as long as such serious deficiencies exist. The AID Mission has attempted to ameliorate the situation through support of the Population Department and its sub-sections and should continue such support, subject to considerations that appear in more detail in the position of this report devoted to the program of the MOH.

Recommendation No. 2: Project Consolidation

The team recommends that every effort be made to institute coordination of public sector (GOE) efforts in family planning service delivery and information/education activities either through the Department of Population of the Ministry of Health or through an independently structured council made up of individuals appointed to the council by the directors of family planning activities of the several government ministries. To the extent possible, private sector agencies should also be allowed and encouraged to join. However, their status in such a council might be different than that of governmental representatives.

To further advance the coordination effort, we recommend that all aspects of the Ministry of Health population work be funded through a single project agreement (94.1; 94.5; 94.8). Exploration should be made of the ways in which other population project agreements with other government institutions could be brought into this project agreement with provision for suballocation of funds to the agency in question. Concomitantly, efforts should be made to identify those projects most suitable for turning over to other funding or technical assistance agencies. The Ministry of Agriculture (formerly Andean Mission) project, for example, seems well suited to such a maneuver.

The team recommends that in the near future all financing of private sector programs in Ecuador be turned over to other (non-AID/Ecuador) funding and technical assistance agencies working in the family planning field. Furthermore, these independent agencies should be encouraged to explore the horizon for new groups with which they might work (eg. journalists, labor organizations, religious groups).

Recommendation No. 3: Immediate Total National Coverage vs. Phased Program Concentration

The team recommends that emphasis should be placed on a phased concentrated approach of services, considering that:

a. The Family Planning effort experiences in the different countries of the world tend to follow a consistent pattern of development. At the beginning of the establishment of a family service program, there are a number of individuals who readily accept family planning because of their high motivation and awareness of the program in terms of what it means to them: job aspirations, opportunities to continue their schooling, stronger and healthier families, etc. These individuals are likely to reside in the more densely populated and accessible areas.

b. In the early stages of FP program development with the phased concentration model, there is no dilution of efforts, thus producing a stronger thrust and a consequent greater impact on the population. This reduces greatly the logistics problem, as compared with a program which in its beginnings attempts to cover the entire country.

c. A diluted over-expanded program makes the evaluation process difficult especially when the logistics of the reporting system impairs the uniformity and promptness of data retrieval and the expected extent of change is too small for detection.

d. A phased concentrated program favors the movement of all program components in a simultaneous (parallel) way, while an over-ambitious national coverage approach can hardly be expected to do so.

e. The phased concentrated approach permits selective development according to

needs and readiness and allows for growth of activities in certain localities with less risk of engendering political issues nationally.

Although some government officials might recognize the population problem and be sympathetic with the attempts to solve it, government position tends to avoid large scale operations.

f. Urban populations have some influence on the values held by the rural population, among other reasons through the ties kept after migration. This points to the desirability of placing program emphasis on urban populations where innovations are usually introduced more easily.

g. The rural areas of Ecuador lack health facilities in which to incorporate family planning activities, thus rendering it practically impossible for national coverage in the light of the Ministry of Health philosophy and policy that family planning should be under the aegis of health.

h. Although the team accepts the fact that there is dire need of family planning in the rural areas, it recommends that the best approach in terms of strategy would be to establish family planning activities all across the board (urban-intermediate and rural), on an experimental basis in the Zone of Manabi, and in the other three regions, efforts should largely concentrate on densely populated areas so as to enhance close supervision and to attain program efficiency. The result of both these approaches should be studied and evaluated and on the basis of findings, subsequent direction of the national program development would be implemented. The team considers the Manabi Zone for the total coverage approach because of its characteristics: homogeneity, dynamism, "ready-to-go" attitude with an energetic, enthusiastic and devoted supervisor.

For the Ecuadorian Family Planning delivery system one must consider that there are four different subcultures in the four defined supervisory zones:

Central

Manabi

Austral

Litoral (with Guayaquil's enormous slum area, where two-thirds of the population live in sub-standard conditions).

The existence of these subcultures implies that different operational means may be required to make the FP program functional in each of these zones. For exploring these means, the phased concentration is more suitable than a nationwide effort.

Recommendation No. 4: AID/Ecuador Mission Monitoring Practices

Opinions differ among persons and agencies in international technical assistance work concerning optimum approaches to achieving effective operation of projects after awards have been granted. These bonuses are subject to bipolar pulls that result from their search for value received, on the one hand, and their desire to help develop self-sufficiency in the country on the other. Practices range from virtual administration and approval of each expenditure by the doner agency to simple requirement of annual reports, with or without fiscal post-audits.

The Ecuador Mission practices fall between the extremes, leaning toward effort at more intimate involvement than the average around the world. This evaluation team, opting for less intimate control, offers its opinions and recommendations on this question with reservation. It is far easier to criticize than to carry on-the-scene responsibility. As a matter of fact, criticism in the opposite direction has come from AID/Washington. You're damned if you do and damned if you don't.

The AID Population Office speaks almost daily with the MOH Population program administrator. In addition to frequent written reports, he receives copies of many kinds of correspondence, even including memos from lower echelon persons addressed directly to him. It is not, however, the mere intimacy of his involvement that is here criticized, although this alone imposes tremendous work demands upon him that must preclude his doing other things of higher priority. It is clear fact that he is fully involved in decision making on program details. This does not seem wholesome. The AID Mission should be content to relinquish power and should achieve other kinds of relationships that foster mutual respect and maturation toward autonomy.

The MOH is the recipient of the largest amount of FP aid and properly occupies the bulk of AID staff time. (Detailed discussion appears elsewhere in this report.) The Population officer keeps himself informed on the other projects as well. Since it is impossible for him personally to maintain the same degree of intimacy with all of them, he has divided the projects among his staff. They are involved in the preparation of Pro Ags and other Agency paper work and also try to observe project field activities frequently. Since it is inevitable that each staff member will be less qualified in one or another respect than some of the project administrators, it is not too appropriate for them to act as advisors. Their role is more that of monitoring. We think their contacts with project personnel may be more frequent than appropriate, yet not necessarily more effective thereby.

Because of the described practices, it is evident that a relatively large staff is required, a total of six, including the Population officer and two who are deputed from an AID contract with MOH. Another is being requested. We believe that reduction in staff would be possible, without jeopardy, if the overall philosophy of monitoring were changed. We recognize, however, that policy and demands from Washington may determine the matter. It is not suggested that all projects should be handled alike. A general pattern to consider could be one that includes the following elements:

a. Agreement in advance on goals, scope and methods of project operation

b. Agreement at the outset on evaluative criteria

c. Autonomy in operation and fiscal controls

d. Quarterly reports on activities, with evaluative criteria, if possible

e. Periodic (semi-annual) spot checks on activities

f. Periodic sample fiscal audit

g. Annual report, evaluative review and decisions on continuation and modification

Recommendation No. 5: Increased Experimentation

The team recognizes the importance of experimental, pilot projects (such as the one currently under way with the National Malaria Eradication Service) to program development and success and therefore recommends that a MOH/Department of Population ProAg budget category with the title "Experimental, Pilot Projects" be created. Expenditure of funds for pilot projects would be based on prior proposal to and approval by the funding agency (USAID/Ecuador or other). While coordination of such pilot work is essential, the details of the projects should be developed autonomously, but with a pre-established limit on maximum time allowable for pilot project completion. Any such project should be designed to demonstrate something (e.g., new approaches to service delivery, new educational or communication efforts) through evaluation. Evaluation of pilot or demonstration efforts should be made by the Evaluation Section of the Department of Population and decisions regarding the continuation or discontinuation of the project as a regular activity would be based on the findings of such an evaluation.

II. GENERAL BACKGROUND, DEMOGRAPHIC AND SOCIOECONOMIC INFORMATION

A. GEOGRAPHIC CHARACTERISTICS

Ecuador covers an area of [illegible] square miles and contains four well defined areas:

1. The Coast - on the Pacific Ocean is a rich portion of land which produces mainly coffee, bananas, cocoa and sugar. The products of the fishing industry are also one of the most important sources of income of Ecuador. The Humboldt Current favors fishing and also provides the climate cooler than in other tropical coasts. The largest city of the country, Guayaquil, is located within this region.

2. The Sierra or the Andean Cordillera produces most of the edibles that are consumed in the country. It contains Quito, the capital of the country.

3. The Oriente (East) - half of Ecuador's area is in this region, which extends from the Andes to the Peru border on the east. Only 3% of the population lives in this area. It is precisely in this desolate area that it has been discovered recently and promises to render Ecuador's future richer. This will place Ecuador in a higher rank of prosperity.

4. Galapagos [illegible] on the continental [illegible] 600 miles from the Pacific coast which has already aroused tourist interest.

B. POLITICAL SUBDIVISIONS

There are 21 provinces, 103 counties (cantones), 488 urban parishes and 677 rural parishes, according to the National Planning Board figures for 1968.

C. DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

There are many variations regarding the demographic and economic situation of Ecuador. There are great disparities in the data from the various sources issuing them. Therefore the following data gives only broad orders of magnitude for some of the variables presented.

The estimated population for early 1971 is about 6,000,000 people.

According to the last census data (1962), 40% of the population were living in the urban areas. The Indian population was 40%, the mestizo population was 40%, blacks 10%, whites 10%. The dependent population (children below age 15 and people above 60 years of age) is 42%.

The crude birth rate is usually estimated at 37 to 40/1000 population; the estimated crude death rate is 9 to 11/1000 population, this yields a 2.6 to 3.6% rate of natural increase. This rate is practically equal to the rate of population growth, due to a negligible net migration rate.

The estimated infant mortality rate is 78 to 80/1000 live births.

The estimated maternal death rate is approximately 1/1000 live births.

Life expectancy at birth is 57 to 59 years.

Socio-economic indices reveal a low standard of living. According to the 1950 Census, 42% of the population lived in huts. By 1962, this proportion had increased to 56%.

According to the 1962 Census:

62% of the dwellings lacked running water

67% lacked sanitary waste disposal

67% lacked electricity

44% consisted of only one room

Thirty percent (30%) of the children failed to enter elementa y school because of lack of educational facilities. Of those who were able to register for the first year of schooling, only 20% completed 5 years of school. A great proportion did not even finish the first. The mode of school years completed was 2.3.

III. HISTORY AND CURRENT STATUS OF THE ECUADORIAN FAMILY PLANNING ACTIVITIES

A. HISTORY

The family planning movement in South America started in the countries of Colombia and Chile.

A great number of international meetings, seminars and workshops were held on the topic of family planning, in which many neighboring countries participated.

One of the participants at an important early meeting held in Colombia was the leading pioneer of the Ecuadorian Family Planning activities, Dr. Pablo Marangoni. He became aware of the implications of these activities for the development of his country and brought back the spirit and dedication needed to awaken consciousness in other people, especially among some community leaders.

At that time, Guayaquil, the most important city of Ecuador from the economic point of view, was attracting many people from the farming areas who started building huts along the river banks and created an enormous slum area. It is estimated that 2/3 of Guayaquil residents live in these slums.

The substandard living conditions of these people called the attention of Drs. Pablo Marangoni and Francisco Parra, both of them physicians but connected with the industrial group. They started motivating other influential people; as one result, the Ecuadorian Family Welfare Association (APROFE) was founded in November 1966.

The process of incorporating the concept of family planning in the people's minds has been, and still is, a difficult and an uphill task.

APROFE was not alone in it efforts, for other groups became interested in the subject, such as the Women's Medical Society in Quito and others. But all of these groups worked separately and without any kind of coordination, with a consequent low total level of performance.

This dispersion of family planning efforts still remains. There are at least 12 different family planning service or educational projects at the present moment.

In early 1969, the Ministry of Health created a Department of Population to carry administrative responsibility for the delivery of services.

At about the same time, the Ministry of Defense organized and established a family planning program directed at military families; this has recently been expanded at some installations to serve a limited number of civilians who live in the vicinity of the armed forces posts.

B. CURRENT STATUS

As stated above, the initial activities were established and developed by APROFE in 1966 with the opening of three clinics: one in Quito, one in Cuenca and one in Guayaquil. At the present time APROFE operates 4 clinics (one in Quito, one in Cuenca and two in Guayaquil).

The Ministry of Health has incorporated family planning in 136 health facilities

(55 in urban health centers and 81 in rural subcenters); the Ministry of Defense has established family planning services at 12 centers (within military hospitals) and 17 subcenters at peripheral army posts; the Women's Medical Society operates two clinics; the Ecuadorial Social Security Institute two and the Department of Agriculture five (formerly called the Andean Mission).

The total number of reported acceptors up to March, 1973 is 50,826, of which 24,822 adopted the IUD method, 21,738 the oral method and 4,366 other methods of contraception (See table below).

According to a study made in 1971 by the Evaluation Section of MOH there is an overall continuation rate of 49.7% among all the acceptors up to the time of the study.

The largest number of enrollments occurred at the APROFE clinics (51.9%); the Ministry of Health has registered (37.4%) and the remaining (10.7%) have been enrolled in the other family planning services.

It should be noted that the Ministry of Health started family planning activities in 1970, 4 years after APROFE had been established.

FAMILY PLANNING ACCEPTORS BY METHOD AND YEAR

Year	IUD	Oral	Others	Total
1966	1,052	583	31	1,666
1967	1,579	1,717	27	3,323
1968	1,720	1,139	56	2,915
1969	1,574	855	133	2,562
1970	2,685	2,070	493	5,248
1971	5,944	6,320	1,558	13,820
1972	7,851	7,213	1,655	16,719
1973*	2,319	1,841	413	4,573
Total	24,822	21,738	4,366	50,826

*There are no data available from the Ecuadorian Social Security Institute nor from the Women's Medical Society to March, 1973.

ACTIVE PATIENTS BY INSTITUTION AND YEAR

Institution	Year						
	1966	1967	1968	1969	1970	1971	1972
Minist. of Health	1,156	3,171	4,432	5,160	1,183	5,921	10,280
APROFE					5,935	8,055	9,572
Armed Forces					157	1,065	2,153
Totals	1,156	3,171	4,432	5,160	7,275	15,041	22,005

IV. MINISTRY OF HEALTH/DEPARTMENT OF POPULATION

A. BACKGROUND

The Department of Population of the Ministry of Health was set up in Guayaquil in February, 1969 with financial assistance provided by AID/Ecuador through a project agreement signed with the Ministry of Health on June, 1968. The first Director of the Department, Dr. Carlos Henriquez, was selected through competitive examination. Dr. Henriquex served as the Director until early 1972 when he was removed from the position by the Minister of Health of the new military government. During Dr. Henriquez' term in office, little significant progress was made in the development of a national family planning program within MOH facilities.

In May, 1972, the Department was transferred to Quito, and a new Director, Dr. Hugo Corral, was named; under him, the operation has been reorganized along functional lines. In the relatively brief period of fifteen months, the Department has made considerable strides in advancing the integration of family planning services into the health care delivery system of the Ministry of Health.

B. ORGANIZATION, STAFFING AND FUNCTIONS

The Department of Population is one of several functional units located within the Division of Health Promotion (Fomento) which in turn forms part of the National Office for Technical Services (see Appendix E - Organigram). Another functional unit under the Division of Health Promotion is the Department of Maternal-Child Health, which, at present, has only a single physician as its entire staff. This relationship may prove important in terms of the position regarding family planning that the Ecuadorian government has taken and also in terms of program planning and development.

The Division of Health Promotion is headed by Dr. Luis Camacho, who also holds the position of Chief of Preventive Medicine of the Ecuadorian Institute of Social Security (IESS). (See elsewhere in this report for information on IESS family planning activities.) The Head of the Department of Population, Dr. Hugo Corral, is an obsetrician-gynecologist and army captain who formerly held the position of coordinator of the Armed Forces Family Planning Program. During his tenure in that position, Dr. Corral served under Air Force Colonel Raul Maldonado, M.D., who was then Director of the Armed Forces Medical Services. Col. Maldonado is the present Minister of Health.

The Director of the Department of Population is responsible for the development of the entire family planning program of the MOH. His functions are principally the elaboration of policy, guidelines and norms; activities which are undertaken in consultation with the Minister of Health with whom he maintains informal but close contact. Dr. Corral is the principal liaison between the USAID/Ecuador population advisor and the Ministry of Health and, by provision of the project agreement, the person with whom the coordination of activities to be carried out under the ProAg are planned.

Within the Department of Population, there are five operational sections; to wit:

a. Coordination and Supervision Section - Dr. Arturo Rodas, Head
b. Training Section - Dr. Mario Moreno, Head
c. Information and Education Section - Lic. Hugo Romo, Head
d. Evaluation Section - Dr. Vladimir Basabe, Head
e. Administration Section - Sr. Francisco Aviles, Head

a. The Coordination and Supervision Section

These sections were only created in September, 1972. At the time of its creation, Dr. Arturo Rodas, a retired military physician with twenty years of service, was named to head it. Initially, he had responsibility for supervision of the entire national family planning program being developed by Ministry of Health. Since it soon became apparent that the assignment could not be carried out by one person, the country was divided into four zones or regions which correspond to regions employed by the Ministry of Health in the conduct of its other activities. Dr. Rodas has retained direct supervisory responsibility for one region (Central) and was, in addition, assigned the responsibility of head supervisor. Three other regional supervisors were hired to fill these newly created posts. Each supervisor has a secretary, a vehicle and a driver provided him to carry out his supervision duties. The follwing table gives specific information about the supervision regions.

Region	Number of Provinces**	Headquarters	Supervisor	No. of Clinics* In Health Centers	No. of Clinics* In sub-centers
Central	10	Quito	Dr. Arturo Rodas	24	34
Litoral	3	Guayaquil	Dr. Guillermo Fierro	14	22
Austral	5	Cuenca	Dr. Marcelo Abad	8	16
Manabi	1	Porto Viejo	Dr. Fausto Andrade	9	9
			Total	55	81

* Number of clinics reported by Dr. Rodas to be providing FP services at the time of our visit. Health centers are located in county seats and other urban areas and subcenters are located in the periphery and in rural areas.

** While Ecuador officially has twenty provinces, one is the Galapagos Islands where no FP services are offered.

The Supervision Section works only with the Ministry of Health Family Planning Program and not with any other public or private agencies which provide family planning services; this is in contrast with the Evaluation Section which works (or receives data from) at least three other FP service agencies.

Among its responsibilities, the Supervision Section undertakes the following:

1) Service Program Expansion

The supervisors introduce family planning services into the ongoing health care delivery of MOH operational units where such services are not already provided. According to Dr. Rodas, the process of incorporation of family planning services begins when the zone supervisor makes a personal visit to the physician or other staff person in charge of the selected health facility. The selection of government health centers or subcenters is based on size of population served by facility, accessibility of the facility and availability of commercial transportation for the population served. At the time of the visit, the supervisor explains the family planning program and its operation; Dr. Rodas emphasized that the principal purpose of the visit was "to motivate the physician" to begin family planning services. If the physician has had no training in clinical aspects of family planning, arrangements are made to send him to Quito or Guayaquil for a short training course. Similar training arrangements are made for other health personnel if they have not previously attended a course. According

to calculations we have made based on data provided by Dr. Rodas, about 60% of the MOH facilities presently offer FP service.

2) Identification of family planning training needs by region

Each supervisor is responsible for preparing a list indicating the training status (with regard to family planning) of all MOH service personnel in his area. Information obtained includes previous training of personnel (type of course attended, location and duration) as well as current training requirements for those not yet prepared. This list is submitted to the Training Section for use in the planning of its training activities. When asked about the role of supervisors in establishing training priorities and selection of personnel for training in their areas, Dr. Rodas implied that all of this was left up to the Training Section and that the superviosr's task was merely to submit to the list.

3) Supervision of Family Planning Activities

Dr. Rodas showed us a supervision work schedule which he has prepared for his region for the second semester of 1973; it listed centers and subcenters on different routes and the dates to be visited for either periodic supervision or for the introduction of family planning services. When queried about the feedback mechanism through which the Supervision Section gets information from the Evaluation Section, Dr. Rodas replied that he obtained some information which suggested problem areas, particularly regarding failure to submit monthly service statistics to the Evaluation Unit. It was not clear to us what mechanisms were used in this process nor to what degree the feedback influenced the programming as well as the implementation of supervisory activities. Further, it was unclear to us as to exactly what "supervision" meant in this operation.

4) Collection of Service Statistics

Supervisors are responsible for seeing that monthly summary reports (see Appendix F) of family planning case loads as well as copies of patient registration forms (see Appendix G) from each clinic are gotten to the Supervision Section in Quito. These are the data upon which the Evaluation Section bases its periodic reports. Supervisors may collect this information directly from each clinic (as is done in Manabi) or they may instruct clinic personnel to mail this data to them or to the central supervision office in Quito. In any case, the service statistics data eventually arrive at Dr. Rodas' office and are then passed to a statistician who works in the Population Department headquarters (Dr. Corral's office); this man maintains a record of registration cards received and once he has recorded the desired data, he forwards the paper work to the Evaluation unit. The purpose and use of this separate data maintenance procedure was not made clear to us.

b. Training Section

The creation of a Training Section within the Department of Population occurred only in July of this year. Previously, coordination of training activities was the responsibility of the deputy head of the Department, Dr. Mario Moreno, who was named to head this new section. Dr. Moreno, an M.D., has a master's degree in demography from the School of Public Health of the University of Puerto Rico.

Because of the recency of formation of this section, Dr. Moreno had not had time to prepare an outline of the training activities which the section proposed to carry out. However, Dr. Moreno assured us that such a plan was being elaborated in conjunc-

tion with both the Supervision and Evaluation Sections.

Dr. Moreno said that the priority problem facing the Training Section is the in-service training of physicians and other health personnel already serving on MOH facilities. This is presumably the same personnel who appear in the lists being prepared by the Supervision Section.

The Training Section has recently embarked upon a program of four day short courses for recent graduates of medicine, professional midwifery and nursing, designed to expose them to family planning concepts and methods. This training aims at preparing these health workers just before they go on a one-year obligatory assignment in rural areas. The course consists of two days of theory and two days of practice. The first such course, offered by the Training Section in conjunction with the Ministry of Health Rural Medicine program, was held in the second week of August this year and was attended by approximately one hundred recently graduated health professionals. (Unfortunately, this team's itinerary did not permit it to observe any of the training sessions.)

In conjunction with the MOH auxiliary nurse training program, the Training Section of the Population Department is providing instruction in family planning as an integrated part of their preparation. According to Dr. Moreno, the MOH trains approximately 150 auxiliary nurses per year in a one year curriculum.

To date, none of the training that the Department of Population has offered has been evaluated. Dr. Moreno said pre-post-test evaluation sheet for courses was being prepared but had not been tried out.

Dr. Moreno complained that his major difficulty in achieving his projected goals was under-staffing. At the present time, the Training Section is composed of Dr. Moreno and a secretary. When asked if he knew about the budget assigned to the Section under his responsibility and the possibility of expanding his staff, he replied that he had heard that additional money might be made available. (The present Pro-Ag (94.1) provides support for a training coordinator and a projectionist besides Dr. Moreno and his secretary.)

Training courses that are carried out by the Department of Population are financed by AID/Ecuador through a portion of the funds available in ProAg 94.4. Twelve thousand dollars is placed in a special account which the Director of the Department of Population, Dr. Corral, has available to draw upon for training activities. This is a rotational fund with reimbursements made by AID/Ecuador as the Population Department presents AID with an accounting for expenditures. Selection of courses to be offered and programming of the training effort is worked out jointly by the Department and AID/Ecuador.

c. Information and Education Section

This section was created in October 1972. It is headed by Lic. Hugo Romo, a health educator who completed an MPH in Puerto Rico in 1959. Since taking his MPH, Mr. Romo has participated in several short courses abroad, including a two-month course on adult education held in East Germany.

Mr. Romo has been with the Population Department since its founding in February, 1969. Until the I & E Section was created last year, he worked almost without help. His first project was to train the MOH health educators (25) in family planning concepts. He said this effort met with little success because for the trainees, "family planning was just another task"; only about ten of the health educators proved responsive. In

late 1970, Mr. Romo was made the head of the National Department of Health Education of the MOH, although still on the payroll of the Department of Population; in this position, he was at least able to exercise some influence regarding the inclusion of Family Planning education in the Ministry's work. Mr. Romo left this position in February, 1972 when there was a change in government.

Until recently, Mr. Romo's main problem seems to have been the struggle with higher-ups to obtain sufficient resources to develop a program. Things have improved recently and he attributed these improvements to Dr. Corral, Dr. Mario Jaramillo and John James. With the creation of the I & E Section, Romo feels that the stage has been set for a good I & E program.

At the present time, the Section is composed of Mr. Romo, two health educators and two social workers working at the regional level (Central and Litoral Regions) and a secretary in the Section office. As of July, 1973, funds have become available to hire two additional health educators and two additional social workers to be assigned to the two remaining regions; these positions will be filled in September, according to Romo.

In part the I & E Section carries out its work by multiplying its potential through training of nurses, auxiliary nurses, social workers, health educators and other health personnel. It also has had responsibility for training Malaria Eradication workers for family planning promotion, a project described elsewhere in this report. It was not clear to the team how this differed in substance from the work carried out by the Training Section. The direct contact which the I & E Section has with the public is based on demonstration work used in the training process. The regional health educators and social workers will provide back-up to auxiliary personnel working at the local level. For example, local health center staff are supposed to work with mothers' and/or parents' clubs and other groups, particularly those made up of community leaders. The I & E Section, through its regional staff, would then be available to provide short "courses" (one two-hour meeting per week over a period of four weeks) and thereby improve the quality of the educational work undertaken at the community level. It is for this purpose that Mr. Romo is seeking mobile A-V units (see below).

Among the problems which Mr. Romo considers to be the most significant impediments to the successful expansion of their I & E work are the lack of educational materials, the lack of vehicles to move the regional staff into the field and the absence of mobile A-V units. To date, the Section has turned out very little A-V or hand-out material. One of the explanations for this is that although the Population Department has been provided with lithographic equipment with which to publish materials, this equipment is used by the MOH for other printing needs and family planning I & E materials are assigned a lower priority. Romo also cited the need for personnel to help design material for publication. He noted that two months ago an expert in social communication was employed part-time to begin designing materials; this person is assigned to the A-V production unit of the Administrative Section and does not work directly with the I & E Section. Preparation of a hand-out for distribution in rural areas has been started and a poster for use in clinics and elsewhere is being prepared. The A-V production unit has also begun the publication of a periodical bulletin on Department activities (see Appendix C). The objectives and target population of the bulletin were not clear.

There has as yet been no contact between staff of the I & E Section of the Population Department and personnel from other agencies who are working in family planning education. However, this will be remedied when the first "seminar on Educational Methods in Family Planning" is held in September under the auspices of the Department of Population, the Ecuadorian Family Protection Association (APROFE) and World Education.

Staff members of all agencies working on family planning education are being invited to attend the seminar.

In spite of the recent improvements in the Section's operational capacity, Mr. Romo feels constricted by political considerations on the conduct of his work. While he is enthusiastic about family planning work and full of vitality, he has sensed restrictions on the kinds of things he can do, such as preparation of news releases or direct educational work with influential national leaders. In spite of this apparent restriction, a periodic bulletin which the Department has begun publishing seems to have served in lieu of news releases (see Appendix H).

Romo is, of course, allowed to work with local community leaders. Whether because of impediment or other reason, the Section is not at present working with the Church or with labor unions. To date, there has been no formal evaluation of their educational work.

d. Evaluation Section

This section was originally established in July 1970, at which time it formed part of the Ecuadorian National Health Service when the Department of Population was located in Guayaquil. Through an agreement between AID/W and Columbia University, provision was made for Dr. Mario Jaramillo, a Colombian physician with a background in family planning work, to head up this unit as a resident foreign advisor. Dr. Jaramillo served in this position from October,1970 to December, 1972. During this period, a program of staff development was instigated.

Under Dr. Jaramillo's direction, a national FP service statistics data system was developed with standardized reporting procedures established for most of the public and private agencies providing family planning services. Dr. Jaramillo devised the uniform patient registration form presently employed by the MOH, the MoDefense, APROFE, and the Quito Women's Medical Society; he also prepared the original monthly summary report form for family planning clinics. This report form has recently undergone revision. In addition to these achievements, Dr. Jaramillo conducted a variety of other evaluation studies (see Appendix J for a complete listing).

In February, 1971, Dr. Jaramillo was joined by an Ecuadorian counterpart, Dr. Vladimir Basabe, founder of the Armed Forces family planning program, who spent one year working in the Evaluation unit as deputy director before going to Mexico for ten months of advanced training at the School of Public Health. Upon his return, Dr. Basabe was named acting director of the Evaluation Section; to date, the Minister of Health has not confirmed his appointment to this position.

At the present time, the Evaluation Section has a staff of eleven people in addition to Dr. Basabe. They are a research assistant (Mr. Pedro Pinto, Colombian, junior statistician, provided by the contract with Colombia University), a sociologist (an Ecuadorian trained in Brasil but with no experience in family planning), two statistical assistants (high school graduates with one or two years of in-service training), two coders (less than high school education), three secretaries, a driver and a custodian. In addition to these positions, the position of deputy director of the section remains vacant; Dr. Basabe would like to see this position filled either by a good administrator or by a medical sociologist capable of analysing data.

In addition to this staff, the Section has available to it the consultation services of Columbia University, especially through Dr. Jaramillo, who comes to Ecuador

about 15 days every three months to consult with the Evaluation Section. Other specialists from Columbia University are also on call for short term consultation as may be deemed needed.

Since Dr. Basabe's return, the Section has completed twenty-eight studies, six of which have been published. Appendix I provides a complete listing of these reports. As may be noted, the reports which have been prepared are principally service statistics maintenance, the area which Dr. Basabe describes as his primary preoccupation.

The Evaluation Section maintains service statistics on the family planning operations of the MOH, the MofDefense, APROFE and the Quito Women's Medical Society. It does not maintain service statistics on the Ministry of Agriculture, Rural Health program (formerly Andean Mission) or on other small family planning operations such as the Foster Parents Plan and independent missionary groups. The service statistics which are maintained are based on new patient registration forms (prepared in duplicate at the time the patient adopts family planning practice with one copy forwarded to the Evaluation Section) and monthly summary reports from each clinic indicating patient load and other data.

The completeness with which MOH clinic reporting takes place varies considerably across geographic regions. (Regions are described above in the section on the supervision unit.) Reporting of the monthly summary data is much more complete (95%) than is the reporting (or forwarding) of the new patient registration forms which accumulate monthly. Regarding the latter, each month each clinic should forward the new patient registration forms filled out during the month; in 1972, only 57% of these monthly accumulations arrived in the hands of the Evaluation Section. The following table shows the reporting rate for both monthly summary reports and new patient registration forms by Region. (Based on 1972 work period)

Region	Clinic/months of operation	Clinic/months monthly summaries	% Completeness	Clinic/mos Registration Forms	% Completeness
Central	234	209	89	168	71
Litoral	219	213	97	88	40
Austral	48	48	100	30	63
Manabi	146	144	98	84	58
Total	647	614	95%	370	57%

In terms of absolute numbers of new patient registration forms which should have been received, the completeness of reporting drops to 46%. That is, according to data from the monthly summary reports, a total of 8,354 new patients were recruited in 1972 but only 3,893 registration forms were forwarded to the Evaluation Section.

Dr. Basabe thought these discrepancies might be due in part to loss in the mails, but that most of the problem was failure by personnel to send the paper. This, in turn, he thought might be due to the time required to complete the registration form

in duplicate (especially where carbon paper was not available). He also noted the time required to complete the form which, for some understaffed clinics, may contribute to their failure to report.

When asked what measures were taken to attempt to improve reporting rates, Dr. Basabe said letters were sent to clinics which did not report and supervisors were informed as well. It was not apparent to us that this was a very thorough effort to improve reporting; however, since the regionalization of supervision is recent, it may have had no impact last year. The efficiency with which the Supervision Section demonstrates its ability to improve reporting definitely merits close attention.

Once the new patient registration data is received in the Evaluation Section, it is coded and punched onto IBM cards. At present, the data processing employs only a sorter but with the assistance of Columbia University staff (Dr. Prem Talwar) a computer program for analysis is being developed and made operational. Data received on the monthly summary reports are tabulated by hand and are used to prepare monthly reports on clinic performance.

Appendix I lists the service statistic reports which the Evaluation Section has planned to prepare on a periodic basis in 1973 as well as special studies along the lines of operations research. Among the latter are evaluations of the malaria eradication family planning program and a KAP type study.

Dr. Basabe emphasized the importance of obtaining a deputy head for the section; he noted that about 40% of his time is taken up with administrative matters with the Director of the Department. He further pointed out that he has been called on to do other things for the Ministry of Health, such as the preparation of a 5-year maternal and child health plan. The preparation of the latter took about 15 days and was almost entirely written by the Evaluation Section. (A good portion of it was copied from Dr. Jaramillo's five-year family planning plan for Ecuador which, in a form revised by Dr. Corral, is currently stalled at the National Planning Board. It should be noted that, among other things, the MCH plan has the same 5-year family planning goals as Dr. Jaramillo's proposal.)

C. CONCLUSIONS AND RECOMMENDATIONS

The team feels that, for all intents and purposes, the Ministry of Health Family Planning Program should be considered "a new ball game" as of May 1972 when it was transferred from Guayaquil to Quito and was given new leadership. Judgements made about return on investment should take this into account.

There is a definite need to provide the Department head with an assistant director who can handle some of the administrative problems as well as work closely with the sections heads. This person should have good preparation in family planning program administration.

We would recommend that key people on the Population Department be given long-term (one year or more) training in public health family planning in a setting in which didactic material is made operational in a service program and where service experience may be obtained as an integral part of the training.

We share the view held by Dr. Corral that the weakest aspects of the program are in training and supervision. Advanced preparation should be given to the person who

will be responsible for the Department's training program; this preparation should include an actual training internship in which the individual gets experience in both pre-service and in-service training techniques and processes. We feel it would be wise to consider selecting the person who will head up the "Family Well-being Training Institute" (ProAg 95.5) program to begin advanced studies in this field as possible. Similar training or advanced preparation should be provided to the person selected to be the head supervisor for the national program (see below). We emphasize again the importance to such training of on-the-job experience and not just classroom instruction.

We do not believe that training a relatively large number of people on a short-term (2-4 weeks) basis is an adequate substitute for in-depth preparation of those individuals who have responsibility for moving the program forward. It is our view that this long-term training is imperative to successful program development.

One aspect of the confusion between staff and line functions in the Supervision Section is found in the dual role which the Section head has: he is both national head supervisor and supervisor for the central region. This should be modified to provide for a national supervisor who has staff functions and a regional supervisor for the central zone with line functions. The person selected for chief supervisor should be well trained in family planning program administration and have personal qualities of vitality and creativity. The latter characteristics may be found in certain persons already working in the program.

We believe that the geographic area of supervisory responsibility assigned to each supervisor is too large (with the possible exception of Manabi) and that without some supervision infrastructure it will be impossible to introduce adequate supervision. As an alternative to this, we recommend that the supervisory efforts within each region be focussed on a manageable number of key operative units, where supervisory procedures can be tested and revised. These may be selected either on the basis of population served or geographic area (one province per region, for example). During a given period, supervision efforts would focus on making the program effective in that area while other areas received minimum supervisory attention. Guidelines for time to be spent in each area of focus need not be rigid, but should be based on evaluation of improvement and ease with which changes can be brought about. We feel that routine supervisory visits are considerably less important than selective supervision based on needs that become evident from routine reports.

With regard to the Evaluation Section, it will only [illegible] efficiency when it has an adequately trained staff of Ecuadorians at [illegible] not just the director. The position of assistant director should be filled by an Ecuadorian with training in social science research methods and [illegible] reasonably good knowledge of statistics. If such a person is not presently available, one should be recruited and sent abroad for training.

The team feels that at this stage in program development the Evaluation Section should place less emphasis on reports of service statistics and other routine data maintenance and should dedicate much more effort to operations [illegible] which address specific matters of program function. That is, the Evaluation Section should help each of the other Sections develop evaluation mechanisms and processes whereby they can evaluate and improve the quality of their contributions to the program objectives. This means evaluation of training and of information and education activities. For some of this work, it may be necessary to bring in short term consultants to help clarify the concepts involved and to provide advice on how effectiveness can be measured. Many of the issues that require evaluation should come from the [illegible]

particularly the Supervision Section wherein responsibility for program monitoring lies. In part, this kind of applied research should include experimental pilot projects which take different approaches toward achievement of the same goals.

Field supervisors should meet on a periodic basis to discuss their work and their problems and to brainstorm on new ways in which the program can be made more effective.

The Information and Education Section should be encouraged to maintain contact with other agencies working in family planning information, education and communication. If production of materials proves difficult within the Department, arrangements for having materials published by privately owned presses should be explored. To accomplish this, it may be necessary to provide some assistance to an independently established private group that could be created (e.g., Association of Family Planning Educators). Such an entity might be able to produce a greater number of educational materials for use by different agencies.

We recommend that one audio-visual mobile unit equipped with movie and slide projectors, tape recorder, generator, etc. be provided to the Information and Education Section. Utility and efficacy of such a unit should be carefully evaluated and, on the basis of findings, the decision whether or not to provide such a unit to other regions would be made.

Returning to the issue of focused supervision (which is part of a phased expansion approach to program development), we recommend that intensive educational efforts be focused simultaneously in areas where supervision is being concentrated since regional health educators and regional supervisors should coordinate their activities closely.

Among the community leaders with whom Information and Education Section works, an effort should be made to employ the "satisfied-user" concept for out-reach and community education work. The "satisfied-user" is a contraceptive adopter from the community who is locally known, speaks the local dialect, and has good rapport with women in the community. The volunteer (colaboradora) working in the Malaria Eradication Family Planning Program might sometimes meet the latter criteria, especially if she is a practicer of contraception. (This would be a worthwhile study within the Malaria Program. Are volunteers who practice Family Planning better recruiters than those who don't?)

V. THE MINISTRY OF DEFENSE PROGRAM

A. GENERAL BACKGROUND

The armed forces population has a birth rate of 44 per 1000; the Ministry of Defense estimates that among its population there are 17,000 couples to be served.

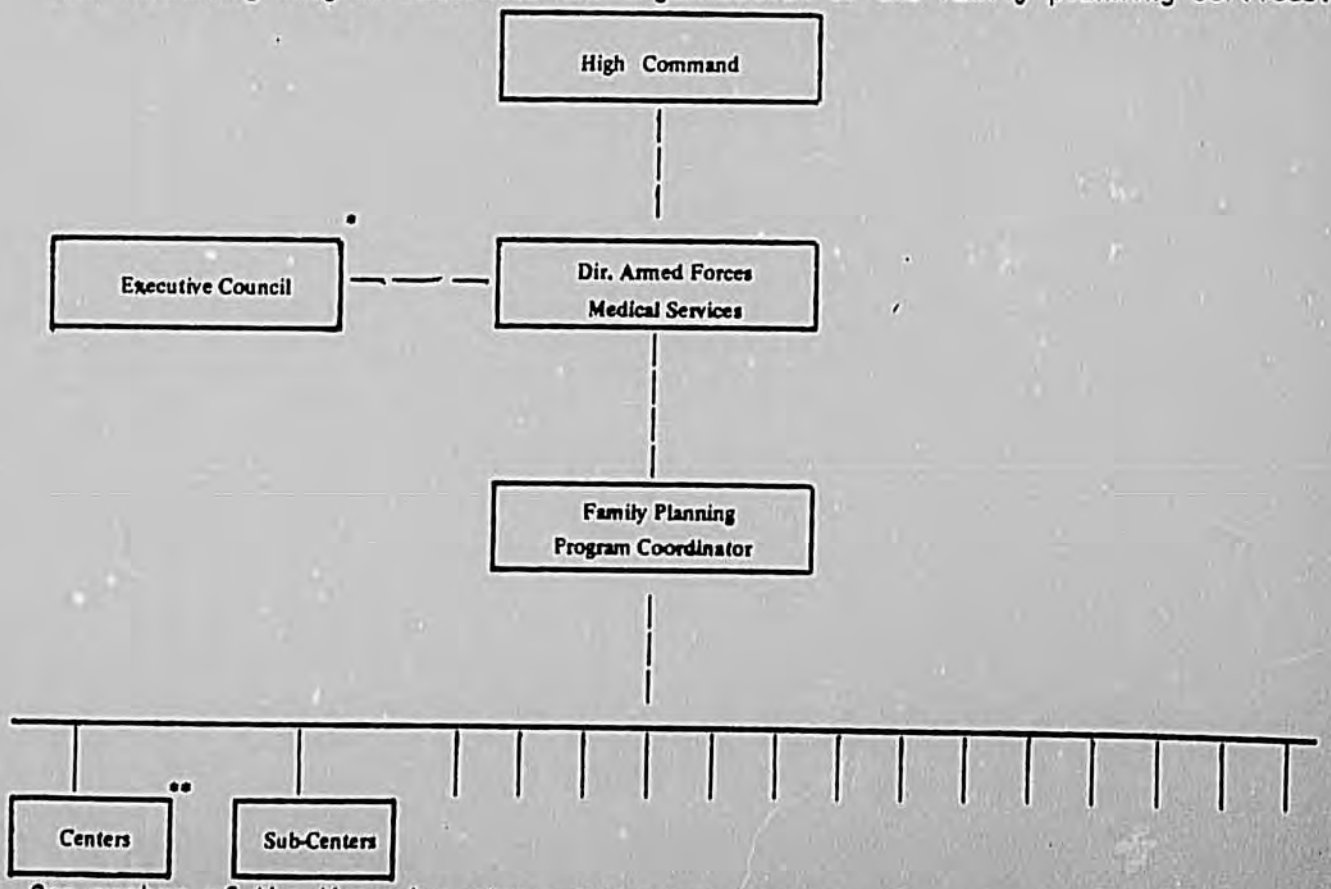
17.4% of the military personnel have families of 8 or more children and 53.6% have 5 or more dependents. The annual per capita income is U.S. $103.

B. ORGANIZATION

In May 1970 the Armed Forces Medical Services of the Ministry of Defense incorporated a family planning service program which includes sex education to women in the reproductive ages who are dependents of military personnel, with the purpose of motivating the military population towards responsible parenthood.

Generally, the program aims to contribute to the general well-being of the members of the armed forces and their families, by providing information and education on family planning and family planning clinical services. Recently, the Ministry of Health requested that the Armed Forces FP services be extended to the civilian population which is in one way or another influenced by the geographical distribution of the military units. An agreement whereby the military will provide such services to civilians was recently agreed upon. The MOD also aims to organize, establish and develop training programs for the personnel involved in these services, early detection of cervical cancer and treatment of infertility cases.

The following diagram describes the organization of the family planning services.



* One member of the three branches of the Armed Forces (Navy, Army, Air Force). Only advisory function.

** Usually in military hospitals

C. FAMILY PLANNING SERVICES

At the present time the program operates 29 family planning clinics (12 Centers and 17 subcenters) distributed on the basis of population at risk (see Appendix K) and at the request of unit commanders or the physician serving these units. It also operates 4 mobile units for information, education and motivational activities.

Six more clinics will be established by the end of 1973 (San Lorenzo, Macas, Arabato, Zumba, Tiputini and Galapagos).

The established output target up to June 30, 1973 in terms of the total number of active patients was 4,575 patients, but the Evaluation Section reported that by June 30, 1973 there were 5,733 registered cases and 4,605 active cases, thus surpassing the targets.

Another phase of the program is the orientation activities directed towards new conscripts. There are an estimated 10,000 draftees/year. These are single young men (19-20 years of age) who serve for one year and, upon returning to civilian life, have already had a good deal of exposure and orientation in family planning information. The outreach is done by a social worker and a sociologist who speak to the troops and visit homes to speak with wives. Family planning clinical services are available any time during working hours; in addition, a period of one hour is set aside exclusively for family planning activities. The physicians receive a special compensation for the delivery of family planning services. The family planning clinics have a separate facility in some centers while other centers and subcenters have a room dedicated to family planning.

The only full-time personnel in the program are the coordinator and his secretary; all others receive additional compensation for time dedicated to family planning.

The basic and most important activities of education and motivation are performed by two trained Health Educators who organize educational programs and supervisory visit schedules. The health educator works in close collaboration with the social workers in the centers, who also do the follow-up work of the program. They are also charged with the scheduling of supervisory visits to the subcenters. Through these coordinated activities (Health, Education and Social Work), a minimum of one monthly visit for educational purposes is assured.

Pre-training of the new personnel in family planning is carried out by means of seminars held in Quito. Periodic in-service training is continually carried out in the form of 8-day seminars (twice a year) in which up-dating of knowledge and techniques is offered. Each clinic situation is discussed in terms of their problems and needs, and alternative solutions are discussed.

There are certain problems in the organization that merit attention. The funding recipient is the High Command which may not attribute high importance to family planning in terms of the relationships of high fertility to military costs, housing, etc. However, the situation has been gradually improving.

All evaluation activities are carried out by the Evaluation Section of the Department of Population of the MOH which feeds the pertinent data back to the Ministry of Defense.

Although at present the Family Planning Program of the Ministry of Defense is financed bilaterally (AID/Ecuadorian Government) there is a proposal submitted to U.N.F.P.A. which has already been approved by the Ecuadorian Government. This proposal is already in the New York office of U.N.F.P.A. and it is expected that this agency will provide $145,000 starting in January 1974.

D. OBSERVATIONS AND RECOMMENDATIONS

We believe that this is a very important program for several reasons, namely: a) It is a military program operating within the context of a military government which reflects government acceptance of family planning. b) It reaches an important population of young men who have not yet begun the process of family formation.

We recommend that a careful evaluation of the eucational and informational activities being conducted by the Ministry of Defense be undertaken to establish the quality of this component and to provide guidance for further effort along these lines.

We also recommend that steps be taken to assess continuation rates among contraceptive acceptors in the program.

VI. OTHER GOVERNMENT SERVICE AND/OR EDUCATION AND INFORMATION PROGRAMS

A. MINISTRY OF AGRICULTURE
OFFICE OF RURAL DEVELOPMENT (FORMERLY ANDEAN MISSION)

This program was initiated as an autonomous program in 1956 at the Province of Chiborazo at La Bamba, under the sponsorship of the United Nations. In 1963 the Government of Ecuador assumed financial responsibility for the program and on February 16, 1973 it was assigned to the Office of Rural Development of the Ministry of Agriculture under the direction of Mr. Sergio Garces.

The Health and Sanitation Section, under the direction of Dr. Mauro Rivadeneira of the above named office was charged with incorporation of family planning services in the 62 health posts of the Andean Rural Area.

Family Planning activities of the former Andean Mission were incorporated in the rural health system beginning in July 1971. The first six months of operations were devoted to the preparation of audiovisual materials (films, promotion pamphlets), training of the medical teams and the physical expansion of the existing 62 rural health posts, which were considerably limited in space. To date, this expansion has been carried out in only 5 health posts, with the partial financial support of AID/Ecuador, which provided the Ecuadorian Government with some of the construction materials and equipment while the construction labor was done by the indigenous people. AID/Ecuador also provided this program with four vehicles to replace old ones (7 in total). Vehicle maintenance--gas, oil, etc.--is the responsibility of the Ecuadorian Government.

1. Organization

The program consists of 7 medical teams composed of a physician, a dentist, a registered nurse, and a sanitary inspector who travel in seven provinces of the Andean Sierra: Imbabura, Cotopaxi, Tungurahua, Chimborazo Norte, Chimborazo Sur, Canar, and Sarguro. These medical teams travel daily according to a programmed itinerary which allows for one weekly visit to each health post. The members of these teams reside in the sites of each of the seven provinces. They serve the 62 rural health posts each of which is staffed with an auxiliary nurse, who lives in the rural post and serves on a 24-hour basis, referring to the nearest Ministry of Health centers the cases that she cannot handle.

Of the total of 62 auxiliary nurses, 50 received a one year training course under the auspices of UNICEF in 1967 in the Guazlan Training Center of the Andean Mission, and 12 others underwent a 6-months intensive course in the same training unit. The median age of the auxiliary nurses is 23-24 years and most of them are married.

Besides her daily extended medical functions, the auxiliary nurse makes home visits for the promotion and motivation towards family planning. They refer those patients living in communities who are not served by the medical team to the corresponding Ministry of Health centers.

A unique feature of this program is that the driver of the vehicle of the medical team who helps in projecting films also performs medical functions such as administering injectable medicines and distributing medical supplies.

2. Reporting

Reports are forwarded monthly to the Headquarters office. Monthly morbidity reports are also made.

3. Future Plans

There is a commitment to incorporate family planning activities in five additional health posts by December, 1973 and to achieve a total of 25 health posts providing family planning services by December, 1974.

4. Conclusions and Recommendations

This program is the oldest organized health service operating in Ecuador and, although limited to the Andean Sierra (mountainous rural) for seventeen years, it is now being extended to other rural areas in the coastal plains.

The program is using the auxiliary nurse in family planning with extended medical functions which fill a great need in these isolated areas. She is also used as a referral agent who sends patients to the existing health centers and hospitals of the Ministry of Health. The fact that she lives in the rural post and is available on a 24-hour basis makes this program unique.

However, this program seems to be working isolatedly from other family planning activities of Ecuador, apparently more so than others, and the reporting system is entirely different from that of the Ministry of Health.

We recommend that a coordinating mechanism be established with the Ministry of Health in order to standardize record keeping and data retrieval thereby permitting uniform processing of the information received through the Evaluation Section of the Ministry of Health.

B. SOCIAL SECURITY INSTITUTE OF ECUADOR

In 1938, a medical treatment service was initiated for limited numbers and categories of factory workers. In 1964, a Preventive Medicine component was added in Quito and Guayaquil. During the years, the categories of workers eligible to join the system have been expanded. Nevertheless, only 350,000 persons are now insured, most of them men. Seldom are services extended to the families of the registered workers, although this is under consideration. The program operates 4 large hospitals, 8 small hospitals and 35 ambulatory treatment units in the country. Mobile units visit factories to treat the workers. Some home visits are made by nurses.

Dr. Luis Camacho is Chief of the Preventive Medicine Services. In May, 1966, he started a Family Planning and cervical cytology service in one location in Quito and has not yet expanded Family Planning to other locations or communities. He hopes to do this in 10 units by the end of 1973, but this seems very doubtful. He has conducted contraceptive studies with Pathfinder Fund and other financial support. He performs laparoscopic sterilizations at the Quito maternity hospital for Social Security enrollees.

This program is not deserving of serious support, except for the educational value of there being some FP work in such an agency. The health infrastructure is weak.

The service does not seem to have high public esteem. Dr. Camacho is not a dynamic chief and is not at all enthusiastic about FP except for his personal role in supported special projects. He receives little cooperation even within the agency.

However, as Director of the Division of Health Promotion he occupies an influential position in the decision-making process, which should be taken into consideration.

C. THE MINISTRY OF SOCIAL WELFARE

The National Office of Social Promotion directly under the Minister of Social Welfare and Labor is headed by Dr. Jorge Martinez who holds a degree of B.A. in Political Sciences from the Central University at Quito and a Ph.D. in Germany. This office has two main subdivisions, the Division of Community Development and the Division of the Integral Promotion of the Family, which work in close coordination with each other. It was with the latter that the Population Office of AID/Ecuador signed an agreement in June, 1970 with the purpose of promoting the development of the rural, suburban and "rur-urban" areas through promotional and educational activities in family planning.

This program places emphasis on the strengthening of family ties (family cohesiveness) taking into consideration social, economic and cultural factors and stressing especially responsible parenthood and sex education.

Sex education is directed first to the parents within the family setting and once these are sensitized to the importance of this aspect of family planning, sex education is directed to the adolescents, first to members of each sex separately and then to mixed (co-ed) groups.

1. Methodology for Family Planning Motivation and Sex Education

a) Socio-economic Survey at Problem Level

A preliminary survey is carried out before sex education activities are offered. This study is directed to heads of families regarding knowledge and attitudes about sex and family planning practices. The disciplines of Sociology, Anthropology, Demography, Economics and Social Services are involved in the preparation of the questionnaire.

b) Community Diagnosis at Problem Level

Community Diagnosis is made by the 35 field workers working in communities through meetings organized by community leaders.

The average attendance at these meetings is one hundred people; the meetings are moderated by the team of field workers (who have had 4 years of university training in social work). Sometimes discussions are carried out in general sessions and other times in small groups. Any community problems revealed by the survey are discussed and are ranked on a priority basis. It is at this level that the subject of family planning is discussed.

c) Organized Community Groups

Organized local groups are strengthened by the "Cabildos" (political and social groups) and the "Mothers Centers".

Mothers Centers: These are organized in both villages and rural areas and are of two kinds: (a) Centers for Nutritional Supplements (CARE program), which promote family planning through advice on the planning of home budgets and (b) Centers for Responsible Parenthood.

Cabildos: These groups are of a political and social nature and act as community leaders who exercise a great deal of influence, including family planning promotion.

"Barrios Comittees" and the "Comittees for the Improvement of the Communities": These are organized groups in the urban area which give orientation, promotion and motivation on family planning.

d) Daily Promotional Activities

1. Interviews are held daily wherever possible (schools, office, community center)

2. Home visits where prospective acceptors receive detailed information about family planning

e) Weekly Promotional Activities

Five-day courses oriented toward 7 different groups are held in the various community centers in the evenings. The groups are:

Couples, married or in consensual union
Mothers
Fathers
Adolescents of both sexes
Male adolescents
High school students
Vocational training students

2. Orientation

Four orientation courses in FP of 8 weeks duration, directed at natural leaders, were held at national and regional levels at Guayaquil, Turcano, Quito and Esmeraldas.

3. In-service training for the professional personnel (social workers) is carried out yearly for the purpose of updating concepts and knowledge about all aspects of family planning.

4. Interinstitutional Seminars

A seminar where various agencies (voluntary and private) were involved was held recently for the purpose of interchanging philosophies, ideas and concepts on family planning. This gave an opportunity to the participants to know what other groups were doing in the field.

5. Coverage

Five provinces are being covered at present, namely: Esmeraldas, Guayas, Carchi, Tingurahua and Pichincha and two more will be added in September 1973: Chimborazo and Azuay.

6. Conclusions and Recommendations

This is a very active and dynamic program of information and educational activities. Its staff appears to be committed to their job. The director of the program gives the impression of having expertise and understanding of his role and works closely with his staff.

It is recommended that this program be given support for expanding its functions, provided that it works in close coordination with other private and government informational and educational activities as well as with agencies providing family planning services.

D. THE NATIONAL MALARIA SERVICE: THE USE OF MALARIA CONTROL WORKERS IN SUPPORT OF THE FP PROGRAM

The Malaria Control Program, which exists in some of the provinces, is administered nationally by a special Department in the MOH. The collaborative effort with the Population Department has been set up in two provinces, Machala and Del Oro. In those areas, the program employs 58 field workers and 8 supervisors who are involved with FP. In addition, there are about 280 volunteer village "leaders".

Villagers are urged to go to the local leader whenever they have fever. A blood smear is made and is picked up by the field worker at the time of monthly visits. At the subsequent visit the report is given. At the time the smear is taken, the leader furnishes four doses of antimalarial medication. The leader has no other duties. She does not educate or advise. She does not seek out cases of fever or admonish those who do not avail themselves of the service. At times, although she holds the position by popular election, she delegates the duties to a member of her family.

In September, 1972, leaders in the selected provinces were oriented to FP and started distributing FP referral coupons. They average 30 to 40 referrals per month for the total group combined. At monthly visits, the field workers collect the coupon stubs; another portion of the coupon is sent to the Evaluation Section of the Population Department in Quito. As yet, we were not able to obtain data on the number of women who actually attend FP clinics after referrals, nor on the continuation experience among those who do.

The field workers are constantly on the road. Five days a week, they visit villages in their jurisdiction and sleep overnight at one or another location, except when near enough to return home, They spend time in the communities, visit homes for checking on fever cases and other purposes and seem, as a rule, to be well known by the people. There is relatively little job turnover among them.

In July, 1973, a pilot experiment was started wherein a number of the field workers distributed FP referral coupons. In their first month, the group did better than the usual output of a comparable number of local malaria leaders. The reason for this experiment was the impression that the leaders did not have high status and were not trusted to avoid gossiping about the women's acceptance of FP. This was reported to us, but not substantiated with evidence.

Conclusions and Recommendations

It is too early to measure results, but a number of aspects warrant comment. It is unfortunate that the leaders do not seem to be of the caliber to act as FP agents

in their respective villages. A resident worker would be a great advantage. The development of such should be given serious consideration, on a pilot basis at first. The resident representative should carry the following functions:

General education about FP in the community

Referral to clinics for FP services

Access for women's complaints after accepting contraception, progressively acquired competence in counselling about the symptoms and selective referral for professional opinion.

Distribution of renewal supplies of oral contraceptives.

Because they are volunteers and limited in education and experience, these duties would be conducted in reaction to requests rather than on an aggressive outreach basis. Obviously, some of the leaders would be less capable than others. Criteria for selection or replacement that pertain to FP duties need to be combined with those that were adequate for malaria work. Popularity alone is insufficient. It would be desirable if the leaders could receive token renumeration, perhaps in the distribution of pills. A mechanism for meaningful supervision needs to be developed. It is not certain that this could emanate from the malaria workers for the expanded functions listed above.

It seems worth while to experiment with referral by the field workers, chiefly because of their reported rapport with the people. Among other considerations, questions that arise and that need observation and analysis are those of the appropriateness of the malaria visiting schedule to FP program needs and the fact that they are all men.

The use of multipurpose workers in FP has been discussed in many places for some time. Collaboration with malaria control programs has been among the patterns discussed and tried. Demonstrations on this approach are needed. If successful methods are found, it would be important for other countries. For this reason as well as for application in Ecuador, the pilot effort should be carefully designed so as to lend itself to evaluation that will answer questions on effectiveness, efficiency and factors contributing to success or failure. If possible, control populations should be part of the assessment.

The proposed AID support is small. The relative pay-off could be high. It would be worth increasing the investment just to make the project a true experiment that is scientifically designed. Then the findings would have meaning and be respected. Otherwise, it is quite likely that the total gain would be a described experience, subjectively appraised, with gross tallies on referrals, but with little definitive evidence.

E. MINISTRY OF EDUCATION: FAMILY LIFE AND SEX EDUCATION PROJECT

Efforts to introduce family life and sex education into the national school system have undergone an important reorganization in recent weeks. Prior to this time, similar efforts were undertaken by a private entity known as the Ecuadorian Center for Family Life Education (CEEF) which, although private, was funded by way of the Project Agreement with the MOH Population Department. The history of the Center's formation, functioning, and internal conflicts will not be outlined here. Suffice it to say that the center did not achieve its objective of integrating these themes into the curriculum of the national school system and was dropped from the MOH ProAg in June, 1973.

Apparently two factions among the former participants have separate organizations, one of which retains the name CEEF, and, although not yet receiveing any outside financing, each one has plans to attempt to integrate itself with the Ministry of Education.

In this contect, Dr. Odette Alarcon, an AID/Ecuador contracted resident advisor specialized in sex education, has created a work group composed of two representatives of the Ministry of Education, two from the MOH, one professional of Dr. Alcaron's choosing trained in sex education and herself. The objective of this group is to program and plan for the introduction of family life and sex education into the shcool system. This will include research (KAP type survey of youth), programming of training requirements, preparation of curriculum materials and introduction of instruction on a pilot basis. As presently coneptualized, the topics would be introduced within health education, which is already part of the overall curriculum.

There is considerable concern on the part of Mr. James that the inclusion of family life, family planning and sex education topics within the more general topic of health education in the school curriculum may result in a dilution of funds and of efforts. According to James, this is another point of contention between USAID/Ecuador and the PAHO regional advisor for maternal and child health programs (Dr. Pedersen). In Mr. James' perception, this is another attempt by PAHO to gain control of population funds (U.N., UNFPA or other) and to utilize them for broader health programs than those relating to family life/sex education.

Conclusions and Recommendations

The team feels that it would be premature to make a judgment about the relative importance or even potential for success of this program. Much will depend on the quality and functioning of the recently created work group and its ability to progress in its assignment. Another important consideration is the amount of time remaining on Dr. Alarcon's contract. Depending, of course, on the rate and quality of progress toward the objectives of this effort, the continued presence of Dr. Alarcon may prove significant to the successful implementation of the program.

The team feels there is little reason to object to the incorporation of the themes in question into the more general area of health education if that is where the Ecuadorians feel it most appropriately fits. The placement of these topics witnin any given curriculum varies from country to country and we have, as yet, no comparative evidence as to which approach is most successful.

F. "ISIDRO AYORA" MATERNITY HOSPITAL IN QUITO

The team met with Dr. Cesar Arguello, Obstetrician and Gynecologist of the largest maternity hospital in Quito, who is in charge of both the out-patient and the immediate post-partum family planning program of the hospital. In the out-patient Department there is an on-going family planning clinic, some mornings and every afternoon. The immediate post-partum family planning clinic has been running since May, 1973.

Hospital auxiliary nurses offer orientation, information and motivation daily in the obstetrical wards. Those patients who accept family planning services are transferred to the immediate post-partum clinics (2), which are housed in a special area adjacent to the obstetrical wards, where they are examined and prescribed the contraceptive method of their choice. The great majority of acceptors select the intrauterine

device. The Dalcon type of IUD is being used at present. The insertion is done on the day the patient is discharged from the hospital (second, third or fourth post-partum day).

Dr. Arguello stated that he had inserted intrauterine devices for 350 patients in a period of 3 months, with a 25% expulsion rate. He is thinking of modifying the Dalcon IUD on an experimental basis and plans to insert 350 Lippes and copper-T type for another 350 patents to establish a comparison in the expulsion rates. Those patients who expel the IUD are then given appointment to the OPD family planning clinic for later reinsertion.

Sixty (60) % of all post-partum women accept some contraceptive method, the IUD mostly, then the oral and a few the condom.

At the hospital, there are 10,000 to 11,000 deliveries per year, with an average parity of six among the mothers. High post-partum acceptance of FP is reported.

There are 3,500 abortion admissions per year, with an even higher post-abortion FP acceptance rate than among the post-partum mothers. It is interesting to note that 10% of the abortion patients admit readily and frankly that the abortion was induced.

Dr. Arguello is starting to use the laporoscopic technique for sterilization, performing one daily at present. His immediate goal is 2 per day and he is training other staff members to extend these services. He states that the Pomeroy method of sterilization had been used for a period of over 30 years. The criteria for sterilization used by the hospital are: over 30 years of age, at least 3 living children, and the husband's consent.

Conclusions and Recommendations

Dr. Baquero, the acting director of the "Isidro Ayora" Maternity Hospital and Dr. Arguello, the man in charge of the family planning unit of the hospital, are both enthusiastic supporters of family planning. Dr. Arguello is a young, energetic and conscientious obstetrician who seems to be highly competent in his field. He operates in the largest maternity hospital in Quito.

We have little doubt that a woman is most motivated right after delivery for family planning and that maternity hospitals offer the best opportunity for introducing family planning. We recommend that the "Isidro Ayora" Maternity Hospital be encouraged to expand these services.

G. AMBATO REGIONAL TEACHING HOSPITAL OF THE MINISTRY OF HEALTH

The team interviewed Dr. Jorge Torres Carrasco, Chief of Obstetrics and Gynecology, Dr. Fausto Torres and two auxiliary nurses.

This hospital serves Ambato and surrounding areas, with an average of 2,400 deliveries per year and 20,000 out-patient appointments annually. They perform 20-30 sterilizations per year, using the Pomeroy technique.

The immediate post-partum family planning service was started two months ago. During the first month of operation they served 30 patients, all of whom had Lippes Loop IUD insertions, with 30-40% expulsion rate.

The nurses provide information, education and motivation to all prenatal, intra-

partum and post-partum patients in the out-patient department as well as in the maternity wards.

Dr. Torres Carrasco expects to expand the services promptly and is asking for financial support from the Ministry of Health to do so. He is also interested in the research aspects of family planning.

Conclusions and Recommendations

This is a very new family planning service that seems to have high potential for development, with consequent significant impact on the reduction of unwanted pregnancies.

Dr. Torres Carrasco impressed us as being a man who is competent in Obstetrics and Gynecology. He showed marked interest in family planning and seemed to be desirous for training in family planning methodology and research. He has applied to Development Associates for a scholarship. We believe he would be a good candidate for advanced training.

There are two main reasons for recommending this program to be encouraged for expansion:

1. As a teaching hospital of the Universidad Central in Quito, it offers a magnificent opportunity to train medical students, midwifery students and other paramedical personnel in family planning.

2. It serves the population of Ambato (60,000 people) and a considerable number of surrounding communities.

VII. PRIVATE SECTOR SERVICE AND/OR

A. THE ECUADORIAN FAMILY PROTECTION ASSO

1. History and general information

This association was founded in 196
Gil and a group of prominent professionals
organization directed to the public and au
and Labor.

From the beginning, this organizatio
entire country with family planning service
goal, the promotional, informational, educ
the concept of responsible parenthood and f
rected toward the public. At the same time,
and private agencies to develop family pla
work realized by this group has been deve

At the end of 1965, APROFE representatives attended the
in Cuenca where the population problem was discussed.
sulting from that meeting was the initiation of the move
Ecuador.

In 1966 APROFE initiated a KAP study on 1,400 women in
has served as a guide for the activities of the Associatio
established family planning clinics in Guayaquil and Cuenca
Center in Quito.

A system of collaboration with hospital
at the Ministry of Health Center #3 in Guayaqu
de los Colorados, Loja, Manabi and Limones.
Women's Medical Society was also established a

At the end of 1966, the first course on Popula
cians was offered in Guayaquil and was repeated
the Association was given official responsibil
medical personnel. The following year, the MOH
Section.

Lately, the Association has directed its efforts to
nication media as vectors of the concept of family

2. Services

In 1972, 5,155 new patients were seen, with a total of
first semester of 1973, 3,307 have already been seen with
reveal that there is a trend for increased number of

Three of the clinics of APROFE are located across the
hospitals as follows:

Guayaquil APROFE Clinic - "Enrique Sotomayor Hospital"
Quito APROFE Clinic - "Isidro Ayora Hospital"
Cuenca APROFE Clinic - "San Vicente de Paul Hospital"

It is interesting to note that in spite of the opposition of the nuns of the Cuenca Catholic [illegible], the APROFE clinic has a load of 40 new acceptors per month and the hospital performs an average of 30 post-partum sterilizations (most of these are concurrently done with Cesarean Sections).

Patients are charged 15-20 sucres for IUD insertions and 5-10 sucres for control visits, depending on their income. Patients on oral contraceptives are charged 5 sucres per cycle or 60 sucres per year.

APROFE, as well as other public and private organizations, stated repeatedly that they charge this "nominal" amount because people prefer services to which they make a financial contribution; they feel that free services lack quality. However, this does not mean that services are denied to people who cannot afford to pay; in these cases, services are free.

3. Reporting and Evaluation

The APROFE clinic record system is the same as the one established by the Department of Population of the Ministry of Health and the data is processed by the Evaluation Section of the Department of Population.

4. Incorporation of MCH Services

According to policy recently established by the Ministry of Health, the Association is now incorporating a pediatric component in every clinic site. They have started following this norm in one of the clinics and expect to extend this activity to the other 3 clinics. The APROFE social worker will refer children in need of pediatric services to the particular pediatrician who will provide the services. Apparently, it is hoped that the addition of this pediatric component will increase continuation rates in the family planning program.

5. Interagency Relationships

All family planning patients evidencing gynecological pathology are referred to the nearby maternity hospitals for treatment. The ethical clinic (at APROFE headquarters) makes gynecological referrals to other hospitals in Guayaquil.

6. Plans for Utilization of Mass Media

As already stated the Association is planning to utilize mass communication media as a means of information, education and motivation in family planning. It plans to utilize T.V. (national channel 10 and channels 2 and 4 in Quito, Guayaquil and Cuenca). The content of the messages has been elaborated by the Department of Information and Education of APROFE.

During October or November they will start using radio, television and the press, which will run family planning messages for a period of seven months. These messages will be pretested in order to assure the reaching of lower-middle and lower socioeconomic groups.

7. Training

As stated above, the Association has been offering training courses in the form of seminars, including sex education through the YMCA in Quito. It has participated in

national symposia and other training activities in family planning in collaboration with other private and government agencies.

8. Conclusions

This is the pioneering program in family planning/population activities in Ecuador. The founders and collaborators of the Association are prominent members of Ecuadorian society and have strong influence in the political world of the country.

Although subscribing to the Minister's policy that family planning is part of the overall health of the Ecuadorian family, APROFE maintains a neutral and independent position, relatively free of political or religious pressures, thus allowing for freedom of action and development of innovative approaches in the delivery of family planning services.

B. WOMEN"S MEDICAL SOCIETY OF QUITO

1. Historical Background

In 1968, six female physicians went to a training course in Obstetrics and Gynecology in Santiago, Chile. This training was financed by the Chilean Family Welfare Society (Asociacion Pro-Bienestar de la Familia Chilena). The training included family planning techniques and procedures, which triggered the interest of Ecuadorian physicians. Upon their return to Quito they made contact with Drs. Pablo Marangani and Francisco Parra in Guayaquil, (APROFE founders).

By July 1968, the six female physicians headed by Dr. Lucina de Cardenas started an information and education campaign in the markets of Quito and in November of the same year they started offering free services consisting of physical examinations and the provision of oral contraceptives given to them by Pathfinder Fund. Later, intrauterine devices were added. These also were provided by Pathfinder on a gratis basis.

When two of the physicians left the project, the four who continued were Drs. Lucina de Cardenas, Ligia Salvador Uria, Piedad Endara and Maria Limaico.

2. Service and Motivational Activities

By 1969 the following family planning services were provided by them on a small fee basis. (5-10 sucres per new visit and 5-10 sucres per control visit for oral contraceptives; 50 sucres for IUD insertions and 10 sucres for IUD control visits. This step was taken as a result of a socioeconomic survey carried out by their social workers.)

a) Pichincha Province - urban and rural - 2 clinics on a daily basis.
b) Santo Domingo de los Colorados - 1 weekend per month. The doctors travel on a Friday afternoon and hold all day Saturday and Sunday clinics.
c) National Police - all women dependents of the police are served on a free basis at the two clinics in Quito: they provide information and clinical services.
d) Army - Only motivational activities among armed forces personnel.

The medical fees discussed above apply only to patients who can afford to pay; the indigent are served free of charge.

It was interesting to hear that police wives and other patients come to Quito for these services from even as far as Rio Bamba which is four hours away by public transportation.

3. Results

The Women's Medical Society reports a total of 3,500 active patients with a very low dropout rate of 10%. The ratio of IUD to oral contraceptives is 2:1. This is due to persuasion from the doctors (because of the great distances patients have to travel and because the method is cheaper to the patient in the long run). They reported an average of 550 control visits per month.

4. Staff

This is composed of four physicians, three social workers, two secretaries, one driver, and two auxiliary nurses.

5. Financing

Up until June 30, 1973, the Ministry of Health had assumed responsibility for the payment of this staff, through ProAg 94,1. The group is negotiating with AID/Ecuador for financing of their personnel through FPIA/NY.

The money collected from the patients pays for rent, equipment and supplies needed to run the family planning program. The balance goes to the Quito Chapter of the National Women's Medical Society.

The annual budget of this program amounts to $20,000 or 500,000 sucres.

6. Coordination Activities

This program works in coordination with the Ministry of Social Welfare, the Society of Fight Against Cancer, Private Hospitals, Suro Maternity Hospital, Private Social Workers Society, Unions, etc.

Conclusions and Recommendations

Although evidently active, this small organization faces some obstacles at present:

1. The Minister of Health is reluctant to sponsor non-profit, private institutions and has stated that all family planning policies will emanate only from the Ministry of Health. This small group apparently desires to act independently.

2. Dissension has developed within the Quito Women's Medical Society concerning the activity. Separation from the Society is under discussion.

We recommend that this group be encouraged to carry out FP activities within guidelines to be established by the Population Department of the Ministry of Health. Because of the extremely high continuation rate that is reported, careful evaluation of the continuation experience should be done with the help of the MOH Evaluation Section in order to corraborate the impression and to identify the factors contributing to such success.

C. "ENRIQUE SOTOMAYOR" MATERNITY HOSPITAL IN GUAYAQUIL

On January 13, 1973, an agreement was signed among the Ministry of Health through its Department of Population, the "Junta de Beneficiencia" of the Guayas Province and the Ecuadorian Family Protection Association (APROFE), by virtue of which these three organizations agreed to establish and develop the Department of Family Planning and Family Welfare in the "Enrique Sotomayor Maternity Hospital of Guayaquil".

1. General Information

This hospital provides prenatal, antepartum, intrapartum and post-partum care to the population of Guayaquil and surrounding areas. It is administered by the "Honorable Junta de Beneficiencia del Guayas", a private non-profit entity. It was built in 1948 with an original capacity of 222 beds which has been expanded to 269 at the present time.

2. Organization and Services

a) Out-patient Department: This is composed of a waiting room, 2 examining rooms, one treatment room and an admission room. The space has become so limited that patients are using the adjacent hall as part of the waiting room facilities. The two examining rooms are inadequate and dysfunctional.

b) Hospital Area: This is divided into three sectors: general, semi-private, and private services.
General Services - There are seven wards housed on the first and second floors of the building with a bed capacity of 209 beds.
Semi-private Services - These are located on the ground floor and consist of eleven three-bed wards with a total of 33 beds.
Private Services - These are located on the second floor, with 27 single-bed rooms.
On the second floor also, there are 6 labor rooms, 2 delivery rooms and 2 operating rooms.
On the ground floor there are 12 labor rooms and 2 delivery rooms with 5 delivery tables.

c) Ancillary Services: Laboratory, X-rays, pathology laboratory, oxygen therapy

d) Human Resources: 1 medical director, 7 in-house physicians, 3 out-patient physicians, usual supporting medical and paramedical personnel

e) Prenatal Service: 10,222 new and 36,972 control visits were made during 1972.

f) Intra and Post-Partum Services: There were a total of 22,865 deliveries, 4,214 abortions and 5,554 gynecological cases discharged from the hospital during 1972, with an average hospital stay of 3.6 days per patient and a bed occupancy rate of 120% (at times, 2 patients have to share a post-partum bed).

3. Family Planning

Although family planning information, education and motivation have been given to the patients by APROFE and acceptors are being served at an APROFE clinic across the street from the hospital up to the present, no immediate post-partum family planning clinic services have been provided thus far.

Through the above mentioned agreement all users of the "Enrique Sotomayor" Maternity Hospital will be provided with family planning services through:

a) An organized mechanism of information, education and motivation within the hospital premises (prenatal and post-partum cases) and through home visits.

b) An organized immediate post-partum family planning service.

c) The establishment and development of a system of follow-uo of cases.

d) Program for the early detection of genital cancer.

e) Study and treatment of infertility cases.

In order to establish and develop organized family planning services within this hospital, expansion of the physical facilities is necessary. To that effect, blue prints for such expansion have been drafted and are waiting approval by the tri-agency council which signed the agreement.

Conclusions and Recommendations

This huge maternity hsopital which serves a large number of women from Guayaquil and surrounding areas presents a magnificent opportunity to concentrate and maximize family planning efforts.

The fact that it is administered by a private non-profit organization enhances the possibilities of making a significant impact on the family planning program of Ecuador, especially when the projected extended physical facilities for family planning become a reality.

We recommend that this program be given all possible encouragement to achieve its goals.

VIII. OTHER RELATED AGENCIES

A. SOCIETY FOR THE FIGHT AGAINST CANCER (SOLCA)

This is a non-profit organization that aims to serve all parts of Ecuador. There are three main SOLCA Centers in Quito, Cuenca and Guayaquil and two small centers in Loja and Portoviejo (Manabi). The three main centers have laboratory, pathology, cytotechnology and hospital facilities, while the two small ones cover only laboratory and cytotechnology services.

Papanicolau smears from the MOH and other FP programs are processed by this organization. All cases resulting in Grade III or more are visited and urged to attend the corresponding SOLCA main center. From there on, SOLCA treats the case (conization, hysterectomy, etc.) and, if still fertile, follows up the patient in family planning.

The Quito SOLCA Center is headed by Dr. Monje, the one in Guayaquil by Drs. Molestino and Narvaez and the one in Cuenca by Dr. Cordero. As explained above, the two small do not have a physician or a hospital facility. Therefore, those cases with a result of Grade III or more from Manabi are referred to the Guayaquil Center and those from Loja to the Cuenca Center.

Pro-Ag 94.1 of AID/Ecuador office provides the following financial support:

Laboratory supplies	$4,000
Cytotechnologists	
3 (Guayaquil)	5,400
2 (Quito)	3,600
2 (Cuenca)	3,600
1 (Manabi)	1,800
TOTAL	$18,400*

*Approximately $19,000 (conversion of sucres into dollars).

There is a military hospital in Loja which provides a cytotechnologist and a pathologist for the reading and diagnosis of Papanicolau smears. Those resulting in Grade III or more are followed up and referred to the Cuenca SOLCA Center for treatment. From the beginning of the program until the end of 1972, 15,610 Papanicolau smears had been processed.

Conclusions and Recommendations

This is an important activity for the attainment of good will. The total cost is relatively inexpensive but only because the volume is still not very large. Careful evaluation should focus on follow-up effectiveness in bringing women in need under care and in the lowering of mortality from genital cancer. As the natural FP effort expands and hopefully reaches a more significant portion of elegible women in the country, policy will need to be established on the relation of routine cytology to the program. For the immediate future, we recommend continued support.

B. DEMOGRAPHIC ANALYSIS CENTER

1. General Background

Mr. Pedro Merlo, economist-demographer, was interviewed by the team.

This center was established through an agreement between AID/Ecuador and the National Planning Board ("Junta Nacional de Planificacion") on June 15, 1972 at the initiative of the University of North Carolina. There are 5 such population laboratories in the world: namely, Kenya, the Philippines, Morocco, Colombia and Quito. The only one that is not charged with research activities is the one under discussion. The Quito Demographic Center is exclusively oriented toward analysis of extant Ecuadorian data. There is a consultant from the University of North Carolina who has visited Quito four times in the past fourteen months for periods of 30 days each. The Center also received consultation from CELADE by Mrs. Carmen Arredo, Dr. Jorge Somoza and Dr. Arevalo for a period of three months. CELADE also programs and processes all the data obtained by the Quito Demographic Center. The staff consists of 5 full-time specialists; 2 economist-demographers (including the director), 1 economist and 2 statisticians with concentration in economics. The agreement in Ecuador was signed for a period of five years, but is renewed annually. The total budget provided by AID/Ecuador for the past year amounted to $116,000, of which $40,000 are encumbered for consultation services provided by the University of North Carolina.

2. Studies

All the work performed by the Center has to be submitted to the National Planning Board ("Junta Nacional de Plnificacion") for approval before it can be published. The Center has not yet published the first study, since the president of the Junta has not approved it. The Center research plan includes studies in the fields of demography, economics, fertility, mortality, migration, education and employment.

3. Conclusions

The team found much disappointment with what they saw at the Center. Leadership is weak. Naive interpretations about tentative data on fertility fluctuations did not attest to high level of scientific work or competence.

There was no clear basis in the program and planning needs of the country for the selection of studies, nor are there indications that the National Planning Board looks to the Center for its planning data. The studies are not such as to generate new data. They consist exclusively of analyzing extant data made available from various past censuses or research. For example, there is no identifiable POPLAB in the North Carolina sense of a defined population in which serial surveys and other investigations might be done over a period of time.

Much of the statistical analysis of data that has been done thus far seems to stem out of technical assistance given by CELADE. Support for CELADE's services has come through the North Carolina contract. In addition, some direct consultation has been given by the University of North Carolina.

This is only the second year of the AID project. More time may be needed to allow for development and maturation of the staff as a working unit and for recognition and utilization of the Center as a resource. The present picture, however, is not promising. Serious and thorough study of the situation is advised, especially with respect to the potential of incumbent personnel, before renewal of support is approved.

IX. USAID/ECUADOR POPULATION OFFICE

A. STAFFING AND FUNCTIONS

The USAID/Ecuador Population Office is presently staffed by two U.S. and one third-country contract personnel and three local-hire "population specialists"; a fourth local-hire position has recently been vacated by a staff member who resigned for health reasons. Two of the local-hire positions are financed through the Pro Ag with the Ministry of Health (94.1).

Mr. John James, the Population Officer, assumes responsibility for overseeing the entire AID population program in Ecuador in addition to taking direct responsibility for certain contracts, such as with the Director of the Department of Population of the MOH. He is also the decision-maker on the AID side of project agreements, who interprets the arrangements and policies and the handling of U.S. funds within the execution of a project.

Mr. Robert Haladay, Assistant Population Officer, is principally responsible for preparation and modifications of Pro Ags, PIO/T's, correspondence and other internal paperwork; this occupies about half of his time. In addition, he is the staff person assigned responsibility for various aspects of P/FP training undertaken in Ecuador, specifically the MOH Population Department Training Section, midwifery training, and training contracts carried out by the Ecuadorian Motivation and Training Center (CEMO).

Mr. Manuel Rizzo, an Ecuadorian former school teacher with some training in statistics in Puerto Rico, is a direct-hire staff member whose principal responsibilities are management of equipment and materials; purchase portions of Pro Ags; preparation of Pro Ags PIO/P.T.C.'s along with Mr. Haladay; local correspondence; and monitoring of the Ministry of Agriculture (formerly Andean Mission) project (94.10). Mr. Rizzo has been with the Population Office longer than any other staff person.

Mr. Victor Velastegui, an Ecuadorian rural educator, has as his principal responsibility central accounting, which includes: bookkeeping and auditing for all USAID Population Office payments, including those made on the Training Pro Ag (94.4); this occupies about 60% of his time. In addition, Mr. Velastegui is the monitor of the Ministry of Defense Pro Ag (94.2). When construction of the P/FP Training Institute is begun, he will also have the responsibility for monitoring the construction as well as expenditure of USAID funds (94.5).

Mr. Rafael Benalcazar, formerly an Ecuadorian school teacher, who in recent years obtained a college degree in social service, has been added to the Population Staff after working in the Mission's Education Office. His principal responsibility is for the Ministry of Social Welfare project (Pro Ag 94.3); this occupies about 60% of his time. In addition, Mr. Benalcazar is the liaison between the Mission and the Women's Medical Society; since funding of this project is due to be transferred to FPIA/New York in September, Mr. Benalcazar has been the AID office contact with that agency. Although recently assigned the responsibility for monitoring the work of the Supervision Section of the Department of Population (MOH), this has not yet occupied much of his time. Mr. Benalcazar is one of the USAID staff persons paid through the Pro Ag with the Ministry of Health (94.1).

Mr. Agustin Cuesta, an Ecuadorian lawyer, has recently left his position with the Population Office for health reasons. Prior to joining the AID staff four months ago, Mr. Cuesta worked closely with Dr. Mario Jaramillo in the Evaluation Section of the

MOH. About 80% of Mr. Cuesta's time on the AID staff had been dedicated to work with the Information and Education Section of the Population Department (MOH) and with the Audiovisual Production Unit located within the Administration Section of that Department.

Conclusions and Recommendations:

It is our impression that the Population Office staff has taken upon itself an unnecessary amount of responsibility for entering into the decision making process of the operation of most of the projects. In addition (or as a result), the staff has become involved in problem resolution within the institutions with which project agreements have been established. (Ex: an armed forces cytotechnician has written the Population Office griping that she hasn't gotten a raise that she thinks she is entitled to under the new Pro Ag with the Ministry of Defense.) We do not believe that the present arrangement of assigning a variety of different tasks to each staff member allows them to make the best use of their time nor does it provide for accountability in terms of individual performance. We feel that use of staff time could be made more effective with some task redistribution.

The team recommends as an alternative for consideration that one U.S. contract person be made responsible for all AID internal and bureaucratic paperwork--Pro Ags, PIO/T's, purchasing, fellowships, and the like. The second U.S. (or third-country) contract person should be a population advisor well trained in family planning program development and administration with a reasonably good knowledge of other aspects (e.g., I.E. & C. work, training, supervision, etc.). This professional would have no administrative responsibilities within the USAID bureaucracy but would be regular contact with the population office administrator mentioned above. This person would work with all public and private Ecuadorian family planning agencies and would provide consultation and technical assistance as required and/or as requested by these agencies. In addition, this advisor would carry a primary role in advising on new program development and proposals. This person's assignment would be to work principally, but not exclusively, with those agencies which receive the bulk of USAID/Ecuador support.

As for the direct and indirect local-hire staff, we believe it will be necessary and advisable to maintain one person in the AID office to work with the Population Office administrator on such matters as preparation of Pro Ags, relations with Ecuadorian institutions, bookkeeping, correspondence, etc. The remainder of local-hire staff should be assigned to the respective program where they should have their offices; they should not, we believe, have their salaries paid throygh the MOH Pro Ag (94.1) but may have them included in the respective Pro Ags which fund the agencies where they would work. Naturally, if there is a consolidation of Pro Ags which allows for suballocation to other ministries through the MOH Department of Population Pro Ag, as we have recommended elsewhere in the report, these individuals should be supported by that route.

Training, Technical Assistance, and Materials (Pro Ag 94.4)

This Pro Ag is designed to provide flexibility in the operation os the Population Office and to allow it to respond to unforseen opportunities in Ecuadorian P/FP work which from time to time present themselves. As a Pro Ag, it is entirely administered by the Population Office of the AID/Ecuador Mission and decisions as to use of the funds are made by Mission staff although usually in conjunction with some Ecuadorian agency.

We do not have a clear picture as to how the use of these funds is programmed. From the data supplied to us by the Mission staff, it appears that the employment of the funds falls along these lines:

Activity	Percent of Budget
Short-term (2 days to 1 month) training courses in-country for varied audiences and conducted by various agencies, especially the MOH Dept. of Pop., the Min. of Social Welfare, CEEF and CEMA	50%
Support for family planning service and information/education work (aux. nurses, Quito Maternity Post-Partum, Women's Medical Society)	37%
Congress Latin American Congress of Ob-Gyn; Social Medicine Congress)	5%
Invitation Travel	4%
Research	3%
Other (book purchase & transportation)	1%

During the past year, the "courses" have brought over 15,000 Ecuadorians into some kind of contact with the concept of responsible parenthood and family planning. Of these, nearly 1300 are health and special service professionals (including about 300 physicians); the remainder are community leaders, teachers, parents, religious leaders and others.

The team recommends that every effort be made to include training budget categories within the Pro Ags established with the respective Ecuadorian agencies which carry out training activities and that the amount allocated for training activities be based on a plan presented by the agency at the time porject agreement is reached. This in turn should reduce the amount of money in the 94.4 Pro Ag. It seems to us that capability for program planning and execution is an important aspect of institution building and that fiscal responsibility for program implementation will help bring about this capacity; annual or semi-annual auditing should provide AID/Ecuador with sufficient assurance that funds are being appropriately utilized.

At the same time, the team recognizes the importance of having a certain amount of money available which is not specifically obligated and which can be used for worthwhile but unforseen events, including invitational travel which will allow Ecuadorians to come into contact with population/family planning work elsewhere. Thus, we do not recommend that this fund be abolished, but believe that it could be reduced to about one third of its present size if the recommendations of this section were implemented.

APPENDICIES

A - Itinerary of Consultant Team
B - Contacts
C - Statements of National Planning Junta and Minister of Health
D - The Cuenca Statement
E - Organizational Chart-Ministry of Health
F - Monthly Summary Report Form
G - Bulletin of Department of Population
H - Press Releases
I - Studies Completed by Evaluation Section under Dr. Basabe
J - Studies and Other Work of the Evaluation Section under Dr. Jaramillo

APPENDIX A

Itinerary of Consulting Team

July 30, 1973 - Briefing sessions in Washington, D.C. with APHA and AID Staff.

July 31, 1973 - Arrival in Ecuador.

August 1, 1973 - Meeting with Mr. John P. James, Population Advisor and Mr. Robert Haladay, Assistant to Mr. James.

August 2, 1973 - Meeting with the Director and section heads of the Department of Population of the Ministry of Health.

August 3, 1973 -

A.M. Meeting with the Director of the Armed Forces Medical Services and the Coordinator of the Armed Forces Family Planning Program.

P.M. (1) Meeting with AID/Ecuador Mission Officers (Mr. Ed Pilli, Dr. John Magill, Mr. James and Mr. Haladay)

(2) AID Population Office Meeting

August 4, 1973 -

A.M. (1) AID Population Staff Meeting continued

(2) Meeting with the Director of Evaluation Section.

P.M. AID Population Staff Meetings concluded.

August 5, 1973 - Review of literature and team discussions.

August 6, 1973 -

A.M. Field trip to Guayaquil - visits to Ministry of Health family planning clinical facilities in Latacunga, Ambato and Rio Bamba.

P.M. Continue to Guayaquil

August 7, 1973 -

A.M. Field Trip to the Province of El Oro - visits to Ministry of Health family planning services in Machala in charge of Dr. Mabel Estupinan.

P.M. Malaria Control/Family Planning Motivation Program Return to Guayaquil

August 8, 1973 -

A.M. (1) Visit to Enrique Sotomayor Maternity Hospital in Guayaquil

(2) Visit Guayaquil

APROFE (I PPF Affiliate) family planning clinic

P.M. (1) Visit to APROFE Headquarters family planning clinic and meeting with Dr. Palo Marangoni and Staff.

(2) Tour in suburbs (slums) of Guayaquil Ministry of Health Facilities

August 9, 1973 -

A.M. Return to Quito

(1) Meeting with Dr. Luis Camacho, Director of Preventive Medicine of the Ecuadorian Institute of Social Security and Director of the Division of Promotion of Health at the Ministry of Health.

(2) Meeting with Dr. Fausto Andrade, Family Planning Supervisor of the Manabi Region of the Ministry of Health.

P.M. (1) Meeting with Dr. Lucina de Cardenas of the Women's Medical Society group offering family planning services.

(2) Meeting with the Minister of Health

August 10, 1973 - All day meeting [illegible]
team to discuss [illegible]

August 11, 1973 - Start drafting of [illegible]

Augusg 12, 1973 -

A.M. - Meeting [illegible]
Department [illegible]

P.M. - Meeting [illegible]
Advisor [illegible]

P.M. - Meeting [illegible]
Mr. Peter [illegible]

August 13, 1973 -

A.M. (1) Meeting at [illegible]
Office - [illegible]

(2) Meeting [illegible]
[illegible] of the Ministry
of Agriculture.

(3) Meeting [illegible]
of AID - [illegible]

P.M. (1) [illegible] clinic [illegible]

(2) Visit to [illegible]
[illegible]

(3) Visit to [illegible]
headed by Dr. [illegible]

August 14, 1973 -

A.M. (1) Visit to [illegible]
Economist [illegible]

(2) Meeting with [illegible]
Welfare [illegible]
Martinez.

P.M. - Visit to the [illegible] and [illegible]
Section of the Department of
Population - [illegible]

August 15 - 18, 1973 - [illegible]

August 19, 1973 - Departure from Ecuador

September 6, 1973 - Meeting in Washingotn, D.C. with APHA staff for review of final report.

September 7, 1973 - Debriefing with APHA staff in Washington, D. C.

September 8, 1973 - Departure from Washington, D.C.

APPENDIX B

CONTACTS:

Ministry of Health

Dr. Raul Maldonado Mejia, Minister
Dr. Luis Camacho, Director, Division of Health Promotion

Department of Population

Dr. Hugo Corral Ruilova - Director
Dr. Arturo Rodas Arias - Head, Supervision & Coordination Section
Dr. Guillermo Fierro, Supervisor, Litoral Region
Dr. Fausto Andrade, Supervisor, Manabi Region
Dr. Mario Moreno - Head, Training Section
Dr. Vladimir Basabe - Head, Evaluation Section
Mr. Hugo Romo - Head, Information and Education Section

Dr. Victor Reyes, Chief, Malaria Eradication Program

Clinic visits - central zone

Aloag Subcenter - Mrs. Marcelo Gomez (wife of attending M.D.)

Ambato Reigonal Teaching Hospital - Dr. Jorge Torres Carrasco
- Dr. Fausto Torres

AID Mission

Mr. Peter Cody, Head of Mission
Mr. Ed Pilli, USAID Executive Officer, But was Acting Director, Cody's Assembler
Dr. John H. Magill, USAID/Program Evaluation
Mr. Harold Haight, Chief, Family Health Division

Population Office

Mr. John P. James, Population Program Officer
Mr. Robert H. Haladay, Assistant Population Officer
Mr. Manuel Rizzo, Population Specialist
Mr. Victor Velastequi, Population Specialist
Mr. Rafael Benalcazar, Population Specialist
Dr. Odette Alarcon, Sex Education Advisor

Ministry of Defense

Dr. Ernesto Iturralde, Director of Armed Forces Medical Services
Dr. Abelardo Aguirre, Armed Forces Family Planning Coordinator

Ministry of Agriculture

Andean Mission
Lic. Patricio Herrera, Health Educator
Sra. Valesca - Chief Nurse
Srta. Renata Jara, Demographer

Ministry of Social Welfare - Dr. Jorge Martinez - Director, National Social Promotion
Mr. Cesar Carrillo, Programmer
Mrs. Zoila Sevilla - National Supervisor of Integral Promotion of Family

National Planning Board

Demographic Research Center
Lic. Pedro Merlo, Economist - Demographer, Director

Office of Census
Ing. Jack Merneo, Director

Ecuadorian Family Protection Association (APROFE-IPPF Affiliate)

Dr. Pablo Marangoni, Founder and Assistant Director
Dr. Guillermo Baquero, Quito Clinic

Isidro Ayora Maternity Hospital, Quito

Dr. Guillermo Baquero - Acting Director Isidro Ayora Maternity Hospital
Dr. Cesar Arguello, Head, Post-Partum F. P. Program
Sra. Teresa Daza, Head Nurse of Post-Partum, F. P. Program

Enrique Sotomayor Maternity Hospital, Guayaquil

Dr. Carlos Gutierrez Gil, Director, Maternity Hospital

Quito Women's Medical Society

Dr. Lucina de Cardenas

Others

Lic. Marcello Villamar, Sales Manager, FYBECA Drug Stores (Chain)
Miss Lindsay Stewart, IPPF/New York
Dr. Hernan Sanhueza, IPPF/New York

APPENDIX C

1. Los programas de planificación familiar forman parte de un servicio de Salud integral y por tanto estarán involucrados dentro de la prestación de servicios médicos.

2. El Ministerio de Salud considera la planificación familiar con criterio médico importante como un programa de fomento de la salud en favor de la madre y el niño.

3. Consecuentemente, esta acción de salud no implica un concepto de control demográfico, sino una acción puramente médica.

4. Las actividades de planificación familiar deben estar bajo el control y supervisión del Gobierno a través del Ministerio de Salud.

5. El Gobierno Nacional puede ejecutar programas de planificación familiar con criterio de paternidad responsable y facilidades técnicas o a través de instituciones u organismos debidamente calificados.

6. La educación e información previa se impone como un requisito importante para que la mujer pueda libremente solicitar el servicio.

April, 1973

(Provided by the Head of the Population Department of the MOH)

APPENDIX C

XII CONGRESO MEDICO SOCIAL PANAMERICANO
QUITO-ECUADOR, 8 - 12 de abril 1973

LA JUNTA NACIONAL DE PLANIFICACION Y EL PROGRAMA DE PLANIFICACION FAMILIAR

Dr. Julio Palacios C.
(Ecuador)

En vista de que existen múltiples agencias que realizan planificación familiar en el país, y estando interesado el Ministerio de Salud Pública en un programa de esta índole, la Junta Nacional de Planificación, establece los siguientes principios:

1.- En el país no existe el peligro de la bomba de explosión demográfica: no existe una correlación entre bajos niveles de vida y densidades de población.

Los recursos actuales del país son suficientes para abastecer a una población muy superior a la actual, si fueran debidamente explotados.

2.- El problema de subdesarrollo estriba, principalmente, en la estructura socio-económica del país, en la falta de desarrollo de una gran mayoría poblacional marginada.

3.- Existe una relación inversa entre la cultura, educación e ingresos de la familia y el número de hijos.

4.- La Junta Nacional de Planificación desea que la planificación familiar sea aceptada libremente por el individuo, y no sea el producto de una imposición.

5.- Desde el punto de vista médico se ha comprobado que la alta paridad, la paridad con espacios reducidos de tiempo, y la paridad antes de los 20 años y después de los 40, influye directamente sobre el aumento de las tasas de mortalidad materna y perinatal.

Por tanto, la Junta Nacional de Planificación establece como política de planificación familiar los siguientes puntos:

1.- El programa debe estar dirigido hacia los grupos poblacionales susceptibles.

2.- Debe ser parte de los servicios de cuidado materno infantil.

3.- La participación de la aceptanto en el programa debe ser libre.

APPENDIX D

SEÑORES DEL DEPARTAMENTO DE PLANIFICACION FAMILIAR
DEL HOSPITAL DE CUENCA:

Los que suscribimos esta comunicación formamos parte de un grupo de actividad clandestina en pro de la revolución latinoamericana con definidas ideas socialistas y anti-imperialistas, respondemos a los intereses populates y de la Historia de las luchas de clases.

Tenemos conocimiento que en vuestro departamento se practica el control indiscriminado de la natalidad, lo que constituye un atentado al futuro de los pueblos latinoamericanos y responde a criterios importados del Imperialismo norte-americano.

Tenemos, también, documentación que nos da a conocer que vuestros programas son financiados por los Estados Unidos, país el que exporta estas ideas de "Planificación Familiar" tratando de yugular el estallido revolucionario de los pueblos pobres del mundo, saqueados por el imperialismo, olvidando que el proceso dialéctico superará estas prácticas reaccionarias de las cuales ustedes son partícipes.

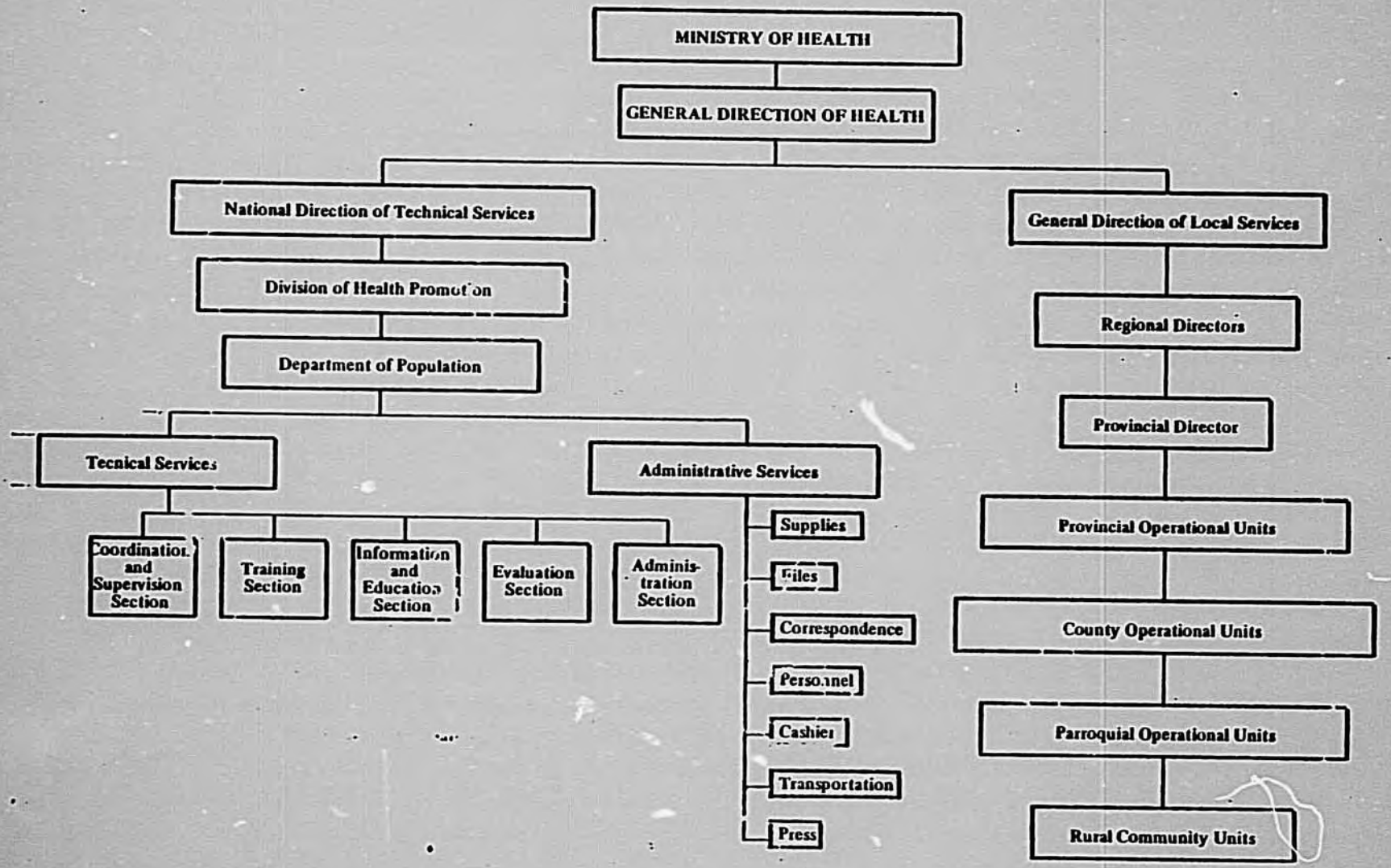
No vamos a ahondar la múltiples razones que tenemos para oponernos tenazmente a que en el Ecuador se continue con estas prácticas indiscriminadas de control de la natalidad.

Por ahora solo queremos prevenirles. Les solicitamos que en vuestro Hospital se suspendan de inmediato estas prácticas así como la campaña propagandística que ustedes realizan en favor de estos, atentatorios a la libertad latinoamericana y criminales métodos. En caso contrario nos veremos obligados a tomar otro tipo de medidas.

Les aconsejamos también no dar parte de esta comunicación a las fuerzas represivas pues hemos de contestar a la violencia reaccionaria con la violencia revolucionaria.

Atentamente,

Comando 331



This is only the part of the organization of the Ministry of Health that relates to population/family planning activities.

APPENDIX E

APPENDIX F

MINISTERIO DE SALUD PUBLICA

DIRECCION NACIONAL DE SALUD

Departamento Nacional de Población

INFORME MENSUAL DE PLANIFICACION FAMILIAR

Centro de Salud _____

DIU	Casos nuevos	
	Cambios de otros métodos	
	Expulsiones	
	Retiros	
	Reinserciones	
	Controles	
	Cambios a otros métodos	
Gestágeno Oral	Casos nuevos	
	Cambios de otros métodos	
	Controles	
	Cambios a otros métodos	
Otros Métodos	Casos nuevos	
	Cambios de otros métodos	
	Controles	
	Cambios a otros métodos	
Traslados de otros servicios de PF		
Traslados a otros servicios de PF		
Casos cerrados		
Charlas a grupos		
Asistentes a estas charlas		
Contactos con instituciones		
Visitas domiciliarias de PF		
Visitas de supervisión recibidas		

Este informe incluye datos desde el ___ de _____ hasta el ___ de _____ de 197_. ___

Fecha _____.

_____

Médico Director

Form. 1-IM

APPENDIX F

FICHA DE INSCRIPCION No. ☐

1. Ministerio de Salud ☐ Defensa ☐ Seguro Social ☐ Aprofe ☐ Otro _____ ☐
2. Zona de supervisión _____ 3. Centro de Salud o Clínica _____

   Nombre completo _____ Dirección _____

   Nombre del marido _____

   Nombre de un vecino _____ Dirección _____
4. Edad de la mujer ____ 5. Hijos actualmente vivos ____
6. Instrucción: Ninguna ☐ Algo de primaria ☐ Algo de secundaria ☐ Secundaria completa o Universitaria ☐
7. Cuanto hace que terminó su último embarazo? _____ meses **Nunca** ha estado embarazada ☐
8. Ha tenido Usted abortos? No ☐ Si ☐ Cuantos? _____
9. Cuantos hijos le han nacido vivos? _____
10. Cuantos hijos le han nacido muertos? (Sin incluír abortos) _____
11. Entonces en total, cuántos embarazos ha tenido? _____ (Verifique la suma)
12. Desea tener más hijos? No ☐ Si ☐ Cuantos? _____
13. Utiliza actualmente algún método para evitar los embarazos? No ☐ Si ☐ Cuál? _____
14. Cuántos meses hace que comenzó a usar ese método? _____
15. Quién le dijo que viniera a este consultorio? Amiga o pariente ☐ Esposo ☐ Por el cupón ☐ Enfermera ☐
    Obstetríz ☐ Trabajadora social ☐ Médico ☐ Otro _____
16. Había sido atendida antes en otro servicio de Planificación Familiar? No ☐ Si ☐ Donde? _____
17. Usó el método que le aconsejaron? No ☐ Si ☐
18. Método escogido: _____ Tipo de DIU o marca de gestágeno _____

    Fecha de esta entrevista _____ Fecha de comienzo del uso del anticonceptivo escogido _____

    Nombre de quien hizo esta entrevista _____

Multigráfica 5441

MINISTERIO DE SALUD PUBLICA

Salud Y población

BOLETIN INFORMATIVO DEL DEPARTAMENTO NACIONAL DE POBLACION

Quito, Julio de 1973 Año 1 No.

[redacted]

Las actividades de Planificación Familiar en el País se iniciaron en 1966, con la fundación de la Asociación Pro-bienestar de la Familia Ecuatoriana (APROFE), entidad privada de la Federación Internacional de Planificación Familiar.

Esta fundación privada prestó servicios desde 1966 hasta 1969 con 3 clínicas que, para el efecto, instrumentó en las ciudades de Quito, Guayaquil y Cuenca. El número de unidades operativas ascendió a 4 en 1969, por la creación de una nueva clínica en la ciudad de Guayaquil; número que no ha variado hasta la fecha.

En Febrero de 1969 se creó el Departamento Nacional de Población del Ministerio de Salud Pública, que inició en 1970 la prestación de servicios al público en 33 Unidades Operativas, número que se incrementó a 48 en 1971, a 62 en 1972 y 134 Unidades Operativas contempladas hasta Junio de 1973, de las cuales ya se han informado 95 hasta la presente fecha.

OTRAS INSTITUCIONES

Paralelamente el Ministerio de Defensa organizó su Programa de Bienestar Familiar de las Fuerzas Armadas, iniciando esta prestación en 1970 con la instrumentación de 8 servicios. Para Marzo de 1971 contaba con 21 Unidades Operativas localizadas en los diferentes hospitales y enfermerías de los repartos militares, que han enviado sus informes a la Unidad de Evaluación del Departamento Nacional de Población.

El Instituto Ecuatoriano de Seguridad Social (IESS), por otra parte, y contando con la ayuda del "The Fathfinder Fund", inició la prestación de estos servicios en 1968, con la instrumentación de una clínica en el Servicio de Medicina Preventiva de la ciudad de Quito.

LA EDUCACION E INFORMACION EN PLANIFICACION FAMILIAR SE EXTIENDE.- El Departamento Nacional de Población, está extendiendo la educación y la información sobre Planificación Familiar, hacia todos los sectores. En la gráfica se aprecia a Auxiliares de Enfermería del Departamento trabajando en este sentido en una de las salas generales de

EDITORIAL

"SALUD Y POBLACION", Boletín informativo del Departamento Nacional de Población, se propone informar al público en general, sobre las actividades que cumple la Institución dirigidas primordialmente al logro del bienestar de la comunidad ecuatoriana.

Dependiente del Ministerio de Salud Pública e incluido en la División Nacional de Fomento de la Salud, el Departamento de Población viene realizando sus tareas con una nueva orientación, caracterizada por una mayor agilidad informativa y tenacidad en la acción, lo cual está repercutiendo en el logro de éxitos en los últimos 16 meses, dentro de la tarea de Planificación Familiar.

Desde la reorganización técnico-administrativa del Portafolio de Salud en Abril de 1972, el Departamento ha superado muchas dificultades, fortaleciendo sus programas. De esta forma sus servicios se están prestando a través de numerosos hospitales, centros y subcentros de salud que el Ministerio administra en casi todas las áreas pobladas de la República, bajo el concepto de que la Planificación Familiar constituye un servicio más de salud en beneficio de la comunidad.

De este modo, las actividades de Información y Educación en Planificación Familiar están consiguiendo buenos logros. El tema de la Planificación Familiar, conocido hasta hace poco por un limitado número de personas, algunas de las cuales incluso lo consideraban como "tabú", actualmente es materia de pláticas, charlas y reuniones corrientes entre personas, grupos e instituciones de diverso orden. Los medios de comunicación colectiva no han quedado atrás en su preocupación por esta clase de problemas y han expresado su opinión favorable.

Expuesta la Planificación Familiar al diálogo de los ecuatorianos de toda condición social y económica, en forma libre y espontánea, queda la gran tarea de seguir suministrando información de todo cuanto concierne a ella, para brindar un cabal conocimiento de la materia y se puedan valorar sus ventajas no como un beneficio individual solamente, sino de toda la comunidad nacional.

Y en esto tratará de contribuir "SALUD Y POBLACION", el Boletín informativo del Departamento de Población, que dará a conocer las novedades que dentro de la materia, se produzcan en nuestro País y en otras partes del mundo.

CUADRO No. 1

Unidades Operativas que laboraron en Planificación Familiar por año e institución

INSTITUCION	1966	1967	1968	1969	1970	1971	1972	1973*
APROFE	3	3	3	4	4	4	4	4
FF. AA.					8	12	20	21
Min. Salud					33	48	62	72
I.E.S.S.			1	1	1	1	1	1
Sociedad de Médicas					1	1	1	1
TOTAL	3	3	4	6	48	67	88	99

De 1966 a 1972 inclusive han ingresado al Programa 46.244 mujeres como aceptantes nuevas, de estas el 51.7°/o lo hicieron a las clínicas de APROFE, el 37.4°/o a las Unidades Operativas del Ministerio de Salud, el 7.6°/o a los Programas de Fuerzas Armadas, el 1.9°/o a la clínica de la Sociedad de Médicas y el restante al 1.4°/o al Programa del I.E.S.S.

CUADRO No. 2

Usuarias Nuevas por Institución y por año 1966 1972

Año	INSTITUCION					
	APROFE	IESS	Min. de Defensa	Min. de Salud	Sociedad Médicas	TOTAL
1966	1.666					1.666
1967	3.314					3.314
1968	2.915					2.915
1969	2.562					2.562
1970	3.316		227	1.705		5.248
1971	4.938		1.363	7.248	271	13.820
1972	5.185	598	1.944	8.354	638	17.989
TOTAL	23.896	598	3.534	17.305	909	46.244
°/o	51.7	1.4	7.6	37.4	1.9	100.00

1973 junio

De las mujeres que ingresaron al Programa como usuarias nuevas, para el 30 de Junio de 1972 se calcula que se mantienen como usuarias activas 23.005, cifra que representa el 49.74°/o de las que ingresaron.

CUADRO No. 3

Número de Usuarias Activas en Planificación Familiar, para todo el Programa por Institución y a mitad de cada año

INSTITUCION	1966	1967	1968	1969	1970	1971	1972
Min. de Salud					1.183	5.921	10.280
Min. de Defensa					157	1.065	2.153
APROFE	1.156	3.171	4.432	5.160	5.935	8.055	9.572
S. de Médicas						188	585
IESS							415
TOTAL	1.156	3.171	4.432	5.160	7.275	15.229	23.005

CUADRO No. 4

Usuarias Nuevas de Planificación Familiar según año y método ECUADOR

AÑO	DIU	G.O.	OTROS	TOTAL
1966	1.052	583	31	1.666
1967	1.579	1.717	27	3.323
1968	1.720	1.139	56	2.915
1969	1.574	855	132	2.562
1970	2.685	2.070	493	5.248
1971	5.942	6.320	1.558	13.820
1972	7.851	7.213	1.655	16.719
TOTAL	22.402	19.897	3.953	46.253

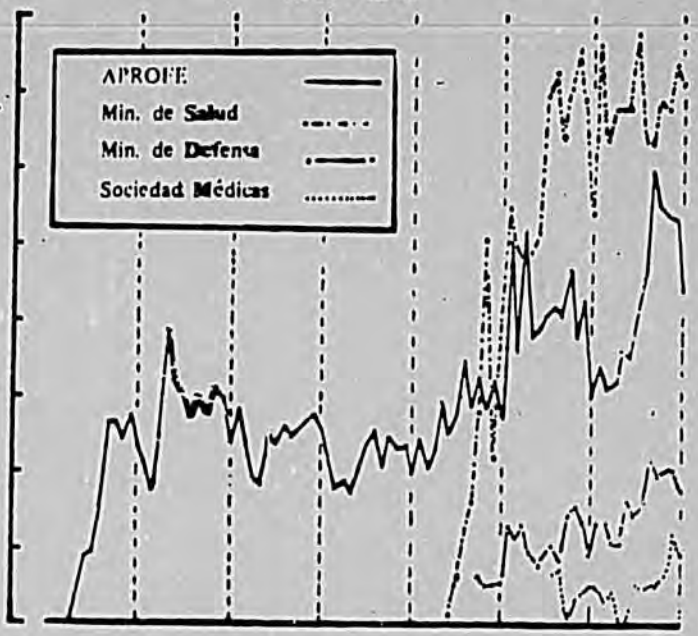
UNA PRESTACION MAS DE SALUD

El Programa de Planificación Familiar que desarrolla el Ministerio de Salud Pública, es instrumentado por los Hospitales, Centros y Sub-centros de Salud del Portafolio, a través de su personal médico como una prestación de salud más.

El criterio del Ministerio de Salud, de integración de servicios, es en esta forma, puesto en práctica.

Basado en este mismo criterio, el Servicio Nacional de Erradicación de la Malaria, SNEM, está utilizando su sistema de penetración en la comunidad, a través de su equipo humano y un vasto grupo de colaboradores voluntarios, para llevar a los hogares de la zona rural de la Provincia de El Oro, juntamente con su mensaje sobre la Malaria, un mensaje de Paternidad Responsable. Este Programa ha recibido inmensa acogida, tanto del personal que realiza esta labor, como de quienes reciben el mensaje, y ha repercutido en un inmediato aumento de la demanda de estos servicios, una vez que la gente ha tomado conciencia de la necesidad de planear su familia para lograr su bienestar y el de la comunidad en general.

USUARIAS NUEVAS POR INSTITUCION Y POR AÑO
1.966 - 1.972



AUTORIDADES Y FUNCIONARIOS
EJECUTIVOS DEL DEPARTAMENTO DE POBLACION

Jefe Nacional	*Dr. Hugo Corral Ruilova*
Jefe, Unidad de Evaluación	*Dr. Vladimir Basabe Fiallo*
Jefe, Sección Entrenamiento	*Dr. Mario Moreno Cadena*
Jefe, Sec. Supervisión y Coord.	*Dr. Arturo Rodas Arias*
Jefe, Sec. Educación e I.	*Lcdo. Hugo Romo Bustos*
Jefe, Sección Administrac.	*Sr. Francisco Avilés Garcés*

Viene de la pág. 3

Por lo mismo anoto que, bajo la premisa de que es obligación estatal proporcionar educación a sus asociados, se busca que no subsista la injusticia que está permitiendo, por ahora, ejercer el derecho de la maternidad deseada, sólo a las mujeres que por sus medios económicos están en condiciones de pagar este servicio.

Finalmente expresó que los programas de Planificación Familiar en el Ecuador, al ofrecerse a un porcentaje amplio de la población femenina que lo solicita, tienen la posibilidad de incluir programas paralelos que benefician con asistencia periódica a las mujeres, como son: la detección precoz del cáncer genital, el diagnóstico y tratamiento de la infertilidad.

PLANIFICACION FAMILIAR EN AMERICA LATINA

Por: Dr. Hugo Corral Ruilova
Jefe del Departamento Nacional de Población.

NOTA: A continuación insertamos una visión periodística de la intervención del Jefe del Departamento Nacional de Población del Ecuador, Dr. Hugo Corral Ruilova, en el XII Congreso Médico Social Panamericano, celebrado en la ciudad de Quito entre el 8 y 12 de Abril de 1973.

Quito: "La Planificación Familiar o la regulación de la fecundidad es un problema candente que ha despertado el interés de este distinguido auditorio; ya ha sucedido esto en congresos y reuniones sobre la materia que se repiten en el mundo con frecuencia inusitada y no cabe duda de la importancia del tema", expresó el Dr. Hugo Corral Ruilova, Jefe del Departamento Nacional de Población, durante su intervención como Moderador, en el XII Congreso Médico Social Panamericano, celebrado en esta capital, entre el 8 y el 12 de Abril del presente año. El Dr. Corral Ruilova enfocó la problemática de la Planificación Familiar en todo el Continente, haciendo una revisión de los problemas que, afronta la humanidad hoy en día y en especial América Latina, en el campo del desarrollo socio-económico y en el avance tecnológico.

DESARROLLO DE UNA NACION Y EL NUCLEO FAMILIAR.-

El Dr. Corral Ruilova, consideró dos aspectos diferentes, dentro de la Planificación Familiar. El primero relacionado "con el desarrollo de una Nación, País o Pueblo, influyendo en su crecimiento vegetativo"; y el segundo "relacionado con el núcleo familiar, con el tamaño de la familia, con el hombre como individuo".

Recordó el Jefe Nacional de Población, que el mundo de hoy afronta problemas que deben ser tomados en cuenta para el futuro de la humanidad. Se refirió al término "Explosión Demográfica" en varias áreas de Planeta, que ha hecho que en aquellos países tengan que adoptarse medidas emergentes para evitar desastres. Señaló entonces que esta situación de sobrepoblación no se ha hecho sentir aún en todos los países del mundo, en igual intensidad, por lo cual las medidas que se adopten para solucionarla no deben ser tan drásticas.

Al referirse a América Latina, el disertante dijo que no se presenta un patrón demográfico único, teniendo cada región del Continente sus propias particularidades que no permiten considerarlo como un todo.

Por lo mismo anotó que las soluciones que se tomen o no, para resolver el problema poblacional, cuando llegue la hora, deben ser privativas de cada Estado, porque "cada país debe estudiar su problema y resolverlo de acuerdo a sus necesidades, una vez que se defina la política más conveniente al respecto".

Sinembargo afirmó que hasta la fecha, los países, en su gran mayoría, no tienen sentado un criterio claro sobre política de población "por ser este problema y el término "Explosión Demográfica", un hecho nuevo en la Historia de la Humanidad, que hace difícil contar con la suficiente información que permita un análisis global de la situación y de sus posibles trayectorias futuras.

PLANIFICACION FAMILIAR Y SALUD MATERNO – INFANTIL.-

El Dr. Corral, afrontó los objetivos de la Planificación Familiar, en general, en los siguientes términos: "Es verdad que un Programa de Planificación Familiar que adquiera cierto tamaño, trae aparejada alguna caída en las tasas de natalidad, pero también se observa una disminución notable de la mortalidad materna e infantil, por las indudables influencias que la multiparidad y los intervalos genésicos cortos tienen en la salud de las madres. El gran número de embarazos a intervalos breves, agotan las reservas maternas de hierro y proteínas. El intervalo entre un embarazo y el siguiente tiene enorme importancia para la madre y sus hijos. El intervalo ideal sería aquel que permitiera al primer hijo no depender de la leche materna y poder caminar antes que llegue el segundo. Cuando el intervalo es menor que el señalado, los hijos en muchas comunidades están expuestos al gran peligro del Síndrome Policarencial, (deficiencia nutricional), y si el niño no camina antes que su madre se embarace de nuevo, tendrá ella la carga adicional de cuidar a dos hijos simultáneamente, uno en sus brazos y otro por nacer. El control del aborto provocado, demostrado como efectivo en el Programa Chileno, la disminución de la mortalidad infantil elevada en familias numerosas y ante la llegada de hijos no deseados, son otras de las razones de salud que justifican un programa de este tipo, aún sin la necesidad de un control demográfico."

NO ES SISTEMA PARA REGULAR EL CRECIMIENTO DE LA POBLACION.-

Por otra parte, el Dr. Corral Ruilova, enfatizó en el hecho de que no tiene porqué considerarse exclusivamente a la Planificación Familiar como un sistema para regular el crecimiento de una población. "La regulación de la fecundidad, la anticoncepción se practicó mucho antes de que se declare el peligro de la Explosión Demográfica", afirmó, para agregar que lo que sucede es que los medios puestos ahora al alcance de la ciencia han resultado más efectivos y más prácticos. *"No necesariamente tiene que asociarse la Planificación Familiar con el control de la natalidad, pues sobre el crecimiento de la población está el derecho inalienable de cada hombre y de cada mujer a tener los hijos que desee y con el intervalo que juzgue conveniente"*, afirmó el disertante, quien recalcó que "este derecho reconocido por todos, sean comunistas o capitalistas, ateos o creyentes, ricos o pobres, grandes o pequeños, ha sido ampliamente proclamado por Organismos Internacionales, Congresos y Reuniones a nivel mundial y, sobre todo, por el hombre en la quietud de su hogar, sin permitir la ingerencia en el seno de su familia."

EN EL ECUADOR.-

Informó que la investigación médico-social ha revelado abrumadora evidencia sobre la disparidad entre el tamaño deseado de la familia y el tamaño real, que alcanza. Esto, naturalmente, se ha ido contra los deseos de los progenitores que han carecido de información acerca de los medios que podrían utilizar para regular el crecimiento de su familia.

Dio detalles acerca de cómo en el Ecuador se produce un fenómeno de la paternidad no deseada, pero impuesta por el desconocimiento de los medios de regulación o la no disponibilidad de ellos.

Sin embargo, el Dr. Corral afirmó que existe una relación inversa muy marcada entre cultura, educación e ingresos de las familias y el número de hijos, asegurando que se debe a la concientización de la mujer, que ha llegado a más alto grado de educación, hacia la Planificación Familiar, sin otra explicación que la utilización de métodos anticonceptivos.

Se preguntó entonces: Por qué razones habría de persistir este privilegio para las mujeres educadas, que posiblemente son las que están más capacitadas para educar a sus hijos y negarles el derecho a la información y los servicios a las campesinas y a las menos favorecidas por la suerte y por la educación.?

Pasa a la pág. 2

[redacted]

MINISTROS DE SALUD DE AMERICA APRUEBAN PROGRAMA DE PLANIFICACION FAMILIAR

"SANTIAGO, 8 (AFP).- La mayoría de los delegados a la tercera reunión de Ministros de Salud de las Américas y el Caribe aprobó un programa de Planificación Familiar, sin subordinarlo a una política demográfica, se informó hoy aquí.

El planteamiento de una Planificación por razones médico-sociales fue expuesto por la delegación chilena y contó con el apoyo de los delegados de México, Colombia, Venezuela, Cuba, Argentina y ECUADOR".

(EL COMERCIO Oct.-9-72)

INSTAN A UNA AYUDA ESTATAL PARA PLANIFICAR LA FAMILIA

"QUITO.- Uno de los temas más trascendentales relacionado con el criterio latinoamericano sobre Planificación Familiar, trataron en la mañana de ayer en forma exhaustiva, los galenos que están asistiendo al XII Congreso Médico Social Panamericano y a la XI Asamblea de la Confederación Médica Panamericana. En cinco grupos de trabajo se discutió la amplia documentación que fue presentada por Chile, Argentina, Venezuela, Colombia y Ecuador.

RECOMENDACIONES

"Es responsabilidad de los Gobiernos Latinoamericanos dentro de una política integral de desarrollo y específicamente dentro de una política de salud, otorgar servicios de Planificación Familiar que incluyan desde la educación hasta la prestación de los servicios correspondientes, que permitan a la mujer o a la pareja el planificar el número y oportunidad en que desee tener sus hijos. Se reconoce a los países su soberanía para formular su propia política en este campo y a la mujer o pareja el derecho de decidir responsablemente sobre su maternidad"

(EL TIEMPO, Abril-10-73)

RECOMIENDAN PLANEAR EL NUMERO DE HIJOS

"LIMA Nov. 12 (AFP).- Recomendando la Planificación Familiar y la cooperación entre el esposo y la esposa concluyó anoche aquí el Consejo Internacional de Mujeres.

Una de las conclusiones del Congreso expresa que la pareja humana debe ser libre para planear conscientemente su vida común y llegar a una decisión respecto al número y esparcimiento de los niños en la familia que está formando"

(EL COMERCIO, Nov.-2[illegible]-73)

LA PLANIFICACION FAMILIAR EN EE.UU. OCUPA SITIO DESTACADO

"WASHINGTON.- La disminución del índice de natalidad en los Estados Unidos es uno de los puntos resaltantes de la evaluación del desarrollo mundial de la población incluida en el informe de la política exterior de la Secretaría del Estado.

La actitud de este País hacia su propio planeamiento familiar ha sufrido un cambio en la última década de una posición de "no es cuestión que incumba al gobierno federal", a la convicción de que la mujer de todos los niveles económicos debe tener acceso a cualquier método contraceptivo que desea".

(EL UNIVERSO, Mayo-9-73)

PLANIFICACION FAMILIAR

"El Estado está en la obligación de proporcionar la educación necesaria, el derecho a la información y los servicios indispensables que servirán como medios para resolver el problema poblacional, se ha expresado en el XII Congreso Médico Social Panamericano que se realiza en esta ciudad. El cumplimiento de esta finalidad engloba la Planificación Familiar como un componente de la salud materna y como expresión del derecho humano. Esta es ya una responsabilidad de los Gobiernos cuyos planes, programas y campos de acción deben consultar una política de salud y de servicios que incluyan desde la educación hasta la prestación de los servicios correspondientes que permitan a la pareja, según sus disponibilidades, determinar el número de sus descendientes".

(EL COMERCIO, Abril-11-73)

IGLESIA CATOLICA RECONOCE DERECHO DE GOBIERNOS PARA LA PLANIFICACION FAMILIAR

"BOGOTA,25 (UPI).- El sacerdote jesuita Alfonso Llano Escobar declaró que la Iglesia Católica reconoce el derecho que tiene un gobierno de adelantar programas de Planificación Familiar.

Manifestó que un País como Colombia, que tiene tan acelerado y desproporcionado crecimiento demográfico, " no sólo cuenta a su favor con el derecho inalienable sino que, recae sobre él la onerosa y urgente tarea de trazarse una gigante política demográfica que se traduzca entre otras cosas en severos programas de Planificación Familiar que cubran todas las áreas del territorio nacional" .

(EL COMERCIO, Junio 26-73)

[redacted]

"Según el Instituto Nacional de Estadísticas, la población total de la República del Ecuador en 1973 alcanza a 6 millones 819 mil 500 habitantes.

El Puerto de Guayaquil tendrá en 1974 un millón de habitantes.

El crecimiento poblacional del Ecuador ha registrado en diez años un aumento de 1 millón 800 mil habitantes.

PROVINCIAS.-

Damos a conocer a continuación las cifras correspondientes a la población de las veinte Provincias del País:

Guayas 1'589.238 habitantes; Pichincha 946.066; Manabí 905.335; Loja 412.358; Chimborazo 406.263; Los Ríos 401.909; Azuay 326.927; El Oro 275.190; Tungurahua 271 690; Cotopaxi 250.609; Imbabura 226.647; Esmeraldas 200 216; Bolívar 193.573; Cañar 142.843; Carchi 128.948; Morona Santiago 46.767; Napo 44.486; Pastaza 25.115; Zamora-Chinchipe 21.020 y Galápagos 4.205 habitantes.

CAPITALES PROVINCIALES.-

Según los datos oficiales, las Cabeceras de cada Provincia tienen la siguiente población:

Guayaquil 924.086 habitantes; Quito 599.300; Ambato 83.619; Cuenca 82.777; Macnaa 73.422; Esmeraldas 71.365; Portoviejo 54.562; Riobamba 58.246; Loja 43.133, [illegible]a 41.513; Tulcán - 24.750; Babahoyo 24.372; Latacunga 18.145; Guaranda 12.154; Azogues 9.555; El Puyo 4.038; Macas 2.395; Zamora 1.809 y Tena con 1. 749".

(* Tomado del EL UNIVERSO, Abril de 1973)

APPENDIX B

El Telegráfo - Agosto 9, 1972

Buenos días, Señor Presidente

En dos o tres ocasiones le hablamos en el pasado sobre planificación familiar. Hoy lo hacemos nuevamente para felicitar desde esta columna al Ministerio de Salud Pública por el "Boletín Informativo del Departamento Nacional de Población" que forma parte de la División de Fomento de la Salud.

.. El primer editorial está escrito en forma clara, precisa, sencilla cual debe corresponder a una publicación de su género. Y, tras poner de manifiesto sus propósitos de información "al público en general", y de referirse a la "nueva orientación "con que el Departamento viene realizando sus tareas, anota la "superación de muchas dificultades" y el "fortalecimiento de sus programas", como consecuencia de "la reorganización técnico—administrativa de Abril de 1.972" .

.. "El tema de la Planificación Familiar —señala el Editorial— conocido hasta hace poco por el número limitado de personas, algunas de las cuales incluso lo consideraban como "tabú", actualmente es materia de plática., análisis y reuniones corrientes entre personas, grupos e instituciones de diverso orden. Los medios de comunicación colectiva no han quedado atrás en su preocupación por esta clase de problemas y han expresado su opinión favorable".

.. Como siempre hemos acordado a este asunto una importancia de primerísimo orden y por cuanto desde hace ya algún tiempo buscamos la iniciación de un debate, a nivel nacional, sobre la materia, no puede menos que complacernos que se reconozca esta prioridad y se otorgue al problema la magnitud que realmente reviste. El nuevo Boletín así lo comprende y lo señala con harta precisión, cuando dice: "Exponer la Planificación Familiar al diálogo de los ecuatorianos de toda condición social y económica, en forma libre y responsable, puede ser gran tarea de seguir suministrando información [illegible] cuanto concierne a ella, pues [illegible] cabal conocimiento de la materia y se [illegible] valores no [illegible] de beneficio individual [illegible] comunidad nacional".

.. Acaso se diga que [illegible] sobre este asunto. Lo de la [illegible] verdad, señor Presidente, [illegible] importancia del problema [illegible] cima de cuanto hayamos podido [illegible] respecto.

[illegible], señor Presidente.

El [illegible]

EL FANTASMA DEL HAMBRE

En lo relativo al problema del hambre es evidente que los recursos científicos actuales pueden lograr, aún sin conquistar tierras nuevas para el cultivo, alimentos más que suficientes para la población mundial, al aumentar el rendimiento y la fertilidad de los suelos. Hay quienes, como Colin Clark, llegan a decir que aun cuando se encabezan las reservas del suelo podríamos continuar la producción de alimentos, utilizando las técnicas de la agricultura sin suelo. El mismo autor, al cabo de exhaustivos estudios, concluye que los recursos naturales disponibles, adecuadamente explotados pueden proporcionar una dieta alimenticia igual a la promedial en Estados Unidos, a una población de 47 mil millones de habitantes.

Concluyó diciendo que en este aspecto, el panorama no es desalentador y la humanidad puede seguir reproduciéndose sin temor al hambre. En realidad, el problema del hambre colectivo es un fenómeno social debido al aprovechamiento inadecuado de las posibilidades y recursos naturales y por la mala distribución de los bienes de consumo.

El Universo Abril 12 de 1.973

QUITO. — Intenso trabajo cumplió el Grupo de Trabajo No. 1, para tratar aspectos relacionados con la Planificación Familiar. La gráfica capta instantes en que los delegados discuten este problema. De izquierda a derecha, constan: doctora Cristina Palma, de Chile; doctor Raúl Zapata, de Chile; doctor Fabián Villalba, de Colombia; doctor Mauricio Sierra, de Paraguay y doctor Ramiro Almeida de Ecuador. (Foto de la Rosa).

Médicos de países latinoamericanos tratan sobre Planificación Familiar

QUITO.— El Grupo de Trabajo No. dos se instaló para tratar sobre la solicitud del Colegio Médico de Bolivia, sobre Asociación Médica Mundial. Constan de izquierda a derecha, doctores Pérez Rueda, de Ecuador; Emilio Villarroel, de Chile; Patricio Silva, de Chile; Raúl Avila, de Paraguay; Galo Alava, de Ecuador; Aquiles Delfino, de Uruguay y Julio Ripa, de Uruguay.. (Foto de la Rosa).

EL COMERCIO

DIARIO INDEPENDIENTE

Quito - Ecuador, Viernes 13 de Abril de 1973

Se propugna una atención médica integral para la población del continente

Aprobó acuerdos en la sesión final

El XII Congreso Médico Social Panamericano y la XI Asamblea de la Confederación Médica Panamericana resolvieron recomendar a los gobiernos latinoamericanos que provean los servicios de planificación familiar, que incluyan desde la educación, hasta la prestación de servicios correspondientes, que permitan a la pareja planificar el número y la oportunidad de tener su descendencia.

Esta recomendación consta en un documento que contiene las conclusiones finales de las reuniones médicas y sobre el criterio latinoamericano sobre planificación familiar y migraciones médicas,, accidentes de tránsito

(Pasa a la 14ª Pág., 3ª Col.)

Con firma de la "Carta de Quito" terminaron congreso y asamblea americana de médicos

La "Carta de Quito" suscrita ayer por los profesionales que asistieron a las reuniones médicas panamericanas realizadas en Quito, propugna la organización de un sistema nacional de servicios de salud que proporcione atención médica integral, del mejor nivel posible, a toda la población.

Reafirma que cualquiera sea la estructura política, social y económica de los países americanos, los gremios médicos deben luchar por mejorar las condiciones de salud y el nivel sanitario de sus respectivos países y al mismo tiempo, "luchar por asegurar la independencia técnica en el ejercicio profesional y evitar su explotación económica".

El documento fue suscrito por todos los médicos que tomaron parte en el XII Congreso Médico Social Panamericano y en la II Asamblea de la Confederación Médica Panamericana. Su texto es el siguiente:

CARTA DE QUITO

El análisis crítico de los

(Pasa a la 14ª Pág., 4ª Col.)

EDITORIAL - "EL COMERCIO" 11 de Abril de 1.973

Planificación familiar

El Estado está en la obligación de proporcionar la educación necesaria, el derecho a la información y los servicios indispensables que servirán como medios para resolver el problema poblacional, se ha expresado en el XII Congreso Médico Social Panamericano, que se realiza en esta ciudad. El cumplimiento de esta finalidad engloba la planificación familiar como un componente de la salud materna y como expresión del derecho humano. Esta es ya una responsabilidad de los gobiernos cuyos planes, programas y campos de acción deben consultar una política de salud y de servicios que incluyan desde la educación hasta la prestación de los servicios correspondientes que permitan a la pareja, según sus disponibilidades, determinar el número de sus descendientes.

Este asunto ha sido muy controvertido y la solución que se lo debe dar depende de muchos factores que deben ser tomados muy en cuenta. Por ejemplo, países con escasa población y exceso de territorio no pueden ser tratados en la misma medida de los superpoblados. Incluso dentro de unas mismas fronteras se debería tomar en cuenta la estructura y las capacidades económicas de las clases sociales. Algunas de ellas pueden mantener sin esfuerzo numerosa prole y otros carecen casi por completo de esa capacidad. Sin embargo por ignorancia las parejas pertenecientes a esta última clase son las que mayor número de hijos tienen, condenados al hambre y a la ignorancia.

Se habla insistentemente en el mundo del peligro de la explosión demográfica. Sin lugar a dudas hay áreas superpobladas que se han visto obligadas a tomar medidas de emergencia para evitar un peligroso desbalance entre la densidad demográfica y la capacidad de producción. Sin embargo en países que no tienen esas características es también necesario preocuparse de la planificación familiar. En lo que respecta a Latinoamérica cada país tiene sus propias peculiaridades y sería impracticable y hasta contraproducente aplicar una política común en esa materia. Cada uno de ellos debe buscar sus propias soluciones mediante la aplicación de una política poblacional que le considere más apropiada.

En consecuencia, es necesario estudiar el problema y tratar de resolverlo de acuerdo a sus características y necesidades. Pero también en lo que respecta a la planificación familiar no sólo se debe tomar en cuenta el control de la natalidad por sí mismo y en sí mismo, es decir como un fin. La familia, el hogar lo forman todos sus componentes, inclusive naturalmente el padre y la madre. Esta última que es la matriz debe ser protegida convenientemente. Es obvio y está científicamente comprobado que la salud y la longevidad de la mujer está en relación directa con la menor cantidad de embarazos que haya tenido. En caso contrario se registra una mortalidad materna considerable, con todas las secuelas que esto significa para la familia y particularmente para los hijos.

En suma la planificación familiar tiene muchas facetas. No es exclusivamente control de la natalidad. Es mucho más que eso. Es el derecho que tiene cada familia de ordenar su vida de manera racional, es decir de acuerdo a su propio albedrío pero sin que sea fruto de la ignorancia o de los prejuicios morales o religiosos.

"EL TELEGRAFO" 10 de Abril de 1.973

Sobre planificación familiar trató ayer el Congreso Médico

QUITO, abril 9 (ERET).— Sobre planificación familiar trató hoy el Congreso Médico Social Panamericano. Se lo calificó de uno de los temas más apasionantes relacionados con el criterio latinoamericanos que asisten al XII Congreso Médico Social Panamericano y a la XI Asamblea de la Confederación Médica Panamericana, abordaron en forma exhaustiva.

Cinco grupos discutieron la amplia documentación, que fue presentada por Argentina, Chile, Venezuela, Colombia y Ecuador. La mesa directiva sobre este aspecto estuvo integrada por los Dres. Emilio Villarroel, de Chile, que la presidió; la doctora Enriqueta de Naranjo, de Ecuador, Secretaria, y el Dr. Hugo Carral, de Ecuador, como moderador.

El tratamiento del tema se inició con el relato oficial que hizo Chile a través del Colegio Médico, se enfocó los subtemas: control de la natalidad y aborto en América Latina. En calidad de participantes expositores, actuaron, la Dra. Tegualda Monreal, de Chile; Dr. Luis Andrés Poch; Dr. Aquiles Delfino y Dr. Tabare González, Uruguay; Dr. Gonzalo Echeverría, Colombia; Dr. Pedro Bertolino, Argentina; Dr. Pablo Marangoni, Ecuador y la delegación de Venezuela

Las conclusiones que se obtuvieron en las varias deliberaciones serán presentadas a la Asamblea Plenaria del Congreso. De acuerdo a lo resuelto, dichas conclusiones y recomendaciones serán presentadas por las organizaciones oficiales que participan en el Congreso, las que, a su vez, someterán los acuerdos y recomendaciones a los gobiernos de sus respectivos países, de creerlo conveniente.

ASPECTOS CIENTIFICOS

Por otra parte, el día de hoy se iniciaron las labores de orden científico. En primer lugar, se realizó una mesa redonda sobre el tema: Cáncer del cuello del útero. Un grupo de profesionales ecuatorianos conformado por los Dres. Jorge Santiana, Luis Dávila, Leopoldo Vinueza, Hernán Noboa, Fabián Corral y César Bueno, presentaron el relato correspondiente.

La mesa directiva estuvo integrada por los Dres. Orlando Pereira, Uruguay, Presidente; Dr. César Argüello, Secretario, Ecuador; y Dr. Alfredo Jijón Melo, moderador, del Ecuador. En su orden intervinieron en la exposición del tema, los Dres. Jorge Santiana, Luis Torres Garcés, ambos del Ecuador; el Dr. Héctor Rodríguez, Chile, y Dra. Rosa de Maturi, Argentina.

Además, de acuerdo con el programa general del trabajo, se inició hoy el cursillo internacional sobre cirugía del tubo digestivo, a cargo de los médicos brasileños, Dres. Arigo Raia y Dr. Oscar Simonsen. Los Temas que trataron los dos especialistas fueron: Tratamiento del cáncer de esófago, tratamiento de la hernia hiatal y tratamiento quirúrgico del cáncer de colón y recto.

XI ASAMBLEA

Por otro lado, esta tarde continuaron las deliberaciones sobre diversos temas de la XI Asamblea de la Confederación Médica Panamericana. En cinco comisiones, los delegados de los diversos países discutieron los temas propuestos en la agenda de trabajo. Las conclusiones y resoluciones que adopten serán estudiadas y aprobadas en las reuniones plenarias que se realizarán en los días siguientes.

OTRAS ACTIVIDADES

En este primer día del Congreso y Asamblea fueron, un almuerzo en el restaurant Equinoccio, ofrecido por el Comité de Damas del Congreso a las esposas de los delegados que están en Quito, y en horas de la noche, se efectuó la noche folclórica en el teatro Nacional Sucre.

Ultimas Noticias Abril 6 de 1.973

200 médicos en certámenes científicos que se inician el próximo domingo en Quito

El aborto en Chile, será uno de los subtemas que será tratado por el Colegio Médico del hermano país, cuando se aborde el tema: Criterio Latinoamericano sobre Planificación Familiar, que será estudiado exhaustivamente dentro del XII Congreso Médico Social Panamericano y la XI Asamblea de la Confederación Médica panamericana, eventos que se inician el domingo próximo en Quito.

Unos 200 —médicos, de los cuales 80 proceden de los demás países sudamericanos, han confirmado ya su participación en las deliberaciones que se cumplirán como parte de la Agenda prevista para ser tratada en los certámenes científicos que se aproximan.

CURSILLO INTERNACIONAL

Además, cerca de 250 profesionales del país a los que se sumarán especialistas médicos del exterior, estarán presentes en el cursillo internacional de Cirugía del tubo digestivo, que será ofrecido por dos de los más famosos cirujanos brasileros, los Drs. O. Simonsen y A. Raja, quienes hablaron sobre el tratamiento del cáncer de Colon y Recto y del esófago, en su orden.

EL TEMA DE ABORTO

En lo que concierne al tema: Criterio Latinoamericano sobre Planificación Familiar, el relato oficial corresponderá al Colegio Médico de Chile. El Dr. Mario Herrera Moor, presentará el subtema del aborto en Chile. El autor, uno de los especialistas más famosos en planificación familiar, señala que en Chile hay un aborto por cada dos nacimientos y, de estos abortos el 66 % son provocados. Agrega que este problema adquiere proyecciones insospechadas si se piensa que sólo en 1968 hubo 230 defunciones de aborto.

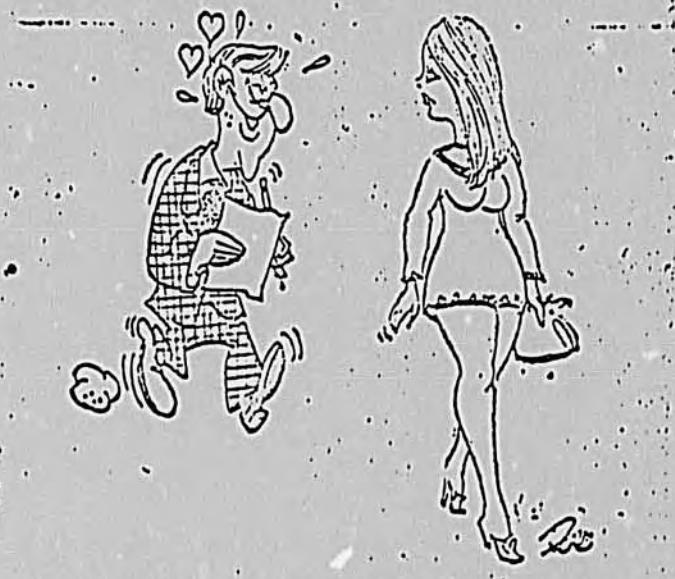
Añade que el aborto provocado constituye el más antiguo y popular método de regulación de la natalidad. En su frecuencia influyen factores sociales, económicos y culturales. Apunta que en los niveles populares hay mayor resistencia a la práctica del aborto y que esto se determina puesto que se registra un 24.5 de aborto por cada 100 embarazos. En la denominada clase media, en donde los ingresos económicos son más elevados y el grado de preparación es mayor, el índice llega al 43.73 por ciento de abortos provocados. Añade el especialista que en este nivel el porcentaje entre solteras y casadas es muy similar.

TRECE PAISES

De acuerdo con el Dr. Herrera Moor, la política de planificación familiar en los diversos países de América Latina carece de nexo común. Los propósitos no son iguales y los medios con que se cuentan no son siempre los mismos y la experiencia de los programas revelan grandes y marcadas experiencias. En la actualidad, únicamente 13 países latinoamericanos tienen planes de regulación de la natalidad controladas y dependientes de los organismos estatales.

EL COMERCIO

Quito - Ecuador, Domingo 15 de Abril de 1973



–Vea bonita: Sería tan amable en ayudarme a hacer la planificación familiar?

APPENDIX I

TAREA PARA EL TERCER AÑO Y C/U DE LOS SIGUIENTES

I. INFORMES PERIODICOS	No.
1. Informes trimestrales de actividades de P.F. de los Centros del Ministerio de Salud (incluyendo Clin. Post-parto)	3
2. Informe semestral de actividades de P.F., programa de FF.AA.	1
3. Informe anual de los Centros del Ministerio de Salud	1
4. Informe anual de actividades de la Soc. de Médicas	1
5. Informe anual de actividades clínicas de APROFE	1
6. Informe anual de actividades de la Unidad de Producción	1
7. Informe anual de actividades de la Unidad de Supervisión	1
8. Informe anual de actividades del CEF	1
9. Informe anual de actividades del Programa de FF. AA.	1
10. Informe anual de actividades de P.F. en Subcentros	1
11. Informe anual de actividades de P.F. con Médicos privados	1
12.. Mini - Informes de cada Centro o Clínica (set)	1
13. Informe anual global del programa	1
SUBTOTAL DOCUMENTOS A PRODUCIR	15

II. MEJORAS AL SISTEMA DE ESTADISTICAS

		No.
14.	Evaluación del sistema del cupón en FF.AA.	1
15.	Extensión del uso del cupón a otros programas (plan)	1
16.	Mecanización del sistema de informes periódicos (plan)	1
17.	Implantación del Tarjetero integrado de citas periódicas Materno - Infantil - P.F. en todos los servicios integrados, y el tarjetero simple de citas periódicas en los demás.	1
18.	Creación de un sistema de registros e informes periódicos para las agencias que todavía no los tienen (CEF, SNEM) o que no se han integrado al sistema general vigente (IESS)	1
	SUBTOTAL DOCUMENTOS A PRODUCIR	5

III. INVESTIGACIONES ESPECIALES

		No.
19.	Evaluación de adiestramiento	1
20.	Terminación del Perfil Demográfico	1
21.	Evaluación del proyecto SNEM	1
22.	Evaluación de proyectos piloto de la Unidad de Producción	1
23.	Segundo estudio de aceptación	1
24.	Segundo Censo de Usuarias	1
25.	Estudio complementario de seguimiento a muestra de inactivas en el censo	1
26.	Evaluación especial del Programa Post-parto	1
	SUBTOTAL DOCUMENTOS A PRODUCIR	8

IV. OTRAS ACTIVIDADES

		No.
27.	Estudio de posible extensión de la evaluación sistemática periódica a otros servicios de salud	1
28.	Participación en actividades de planeación	1
29.	Participación en actividades de adiestramiento	1
30.	Participación en actividades de coordinación	1
31.	Asistencia técnica a otras oficinas	1
	SUBTOTAL DOCUMENTOS A PRODUCIR	5

V. DISEÑO Y EJECUSION DE OTROS ESTUDIOS ESPECIALES QUE EL DESARROLLO DEL PROGRAMA REQUIERA

APPENDIX J

-EVALUATION UNIT

WORK DONE DURING THE SECOND TRIMESTER

TO: CHIEF OF THE NATIONAL POPULATION DEPARTMENT
DR. HUGO CORRAL RUILOVA

FROM: CHIEF OF EVALUATION UNIT
DR. VLADIMIR BASABE FIALLO

I. - OFFICE ORGANIZATION

In the present report I am informing you, that the organization of this office, at the present time is almost completed, the personnel is working in perfect conditions and they are demostrating great spirit of work and cooperation. About the adecuation of the house, I have to inform you that this has not been finished yet, even if we have asked the architect many times to do this, until this moment the bathrooms and the running water connections are not finished.

During these three months the telephone plant, which is working in perfect conditions, has been installed. The conference-room is finished, but it cann't be utilized because the electric current system doesn't have enough capacity for the functioning of the audio visual equipment; for this reason we are changing the electric instaliations

In respect to the assessorship, I have to indicate that during the current four months since the last visit of Dr. Mario Jaramillo we have only received one letter in which he sent us the corrections of the Service Statistics Instructive.

II. - PERIODIC EVALUATION. -

The Graphic we present now, shows the situation in which the Evaluation Works are at the present time.

In the Graphic, what is marked with number one were works made during the first trimester and what appears with number two is what we have done in the second trimester, material of this report.

GRAPHIC N° 1

WAY IN WHICH THE PERIODIC EVALUATION WORKS MADE BY THE UNIT ARE FROM JANUARY 1 TO JUNE 30

STAGES	STUDIES										
	1	2	3	4	5	6	7	8	9	10	11
Preliminary Design	1	1	1	1	1	1		1	1	1	2
Data Recolection	1	1	1	1	1	1		1	1	1	2
Data Elaboration	1	1	1	1	1	1		2			
Data Tabulation	1	1	1	1	1	1		2			
Data Presentation	1	1	1	1	1	1		2			
Analysis	1		2			2					
Reports	1		2			2					
Publication	1		2			2					

1.- Health Centers activities Report in the Family Planning Program. From January to August 1. 972 in The Ministry of Health.

2.- Annual Report of clinical activities for the Welfare of the Ecuadorian Family (APROFE).

3.- Annual Report of clinical activities of Family Planning Program in the Air Force (FF. AA.) 1. 972.

4.- Health Centers Annual Report in the Family Planning Program of The Ministry of Health. 1. 972.

5.- Annual Report of Family Planning activities of Medical Society. 1. 972.

6.- Short Report about Operatives Units activities of The Ministry of Health in Family Planning Program.

7.- Annual Report of Family Planning Program activities of the Ecuatorian Institute of Social Security. (I. E. S. S.).

8.- First Trimestral Report of The Ministry of Health. 1. 973.

9.- First Trimestral Report of The Air Force (FF. AA.) 1. 973.

10.- First Trimestral Report of The Association for the Welfare of the Ecuadorian Family. 1. 973.

11.- Health Ministry Semestral Report. 1973

III.- SPECIAL STUDIES

Studies Denomination:

1.- Accion Plan for the Evaluation Unit in 1. 973.

2.- Study for the implementation of Health Programs in Machachi Valley

3.- Study of the intervention of National Service of Malaria Erradication (SNEM) in Family Planning- El Oro Province.

4.- Calculation of avoided events in a possible Family Planning Program in the Ecuadorian Institute of Social Security. (I. E. S. S.).

5.- Calculation of the contraceptives that are going to be used in the next five years for the National Program.

6.- Statistical Pictures about the National Program Evaluation from 1. 966 to 1. 977.

7.- Distribution Plan of 150 Auxiliary Nurses in the Operative Units of The Ministry of Health.

8.- Plan to distribute 20. 000 coupons in the country.

9.- Welfare Family Program Plan of the Enrique Sotomayor Maternity, Guayaquil.

10.- New System of Service Statistics.

11.- Design of coupon's new system for the use of SNEM and of Auxilliary Nurses.

12.- Formats elaboration to compile data about Operative Units.

13.- Life Tables elaboration of Intrauterine device in APROFE.

14. - Script movies SNEM.

15. - Design of a Family Planning course for auxiliary nurses.

16. - Plan to open the Program in 15 hospitals.

17. - Training Plan for Hospitals Directors and gynecologists.

18. - Recount of Data for the Population Council and IPPF.

19. - Recount of Data for Latin American Center of Demography (CELADE).

20. - DOC Program Study (Opportune Detection of Cancer) in Lazaro Peña Hospital.

21. - Maternal Mortality Study in Isidro Ayora Maternity.

22. - Study of Program Factibility of Family Planning in Los Rios Province.

23. - CAP Survey (Knowledge, Attitudes and Practice in Los Rios Province).

24. - Bases of an Infantile Maternal Program of Esmeraldas.

(Look Graphic N° 2 - Next Page)

IV. - OTHER ACTIVITIES. -

1. - The Evaluation Unit Director submitted the Population Dynamics Project during a week.

2. - The Unit Director intervened in The Ministry of Public Health Meeting.

3. - The Unit Director traveled to El Oro Province with the objective of the elaboration of the SNEM movies and to coordinate and to Modernization Coupon changes.

4. - With respect to training, we have carried out the following activities:

1. - The Unit Director has given conferences in the Air Force (FAE).

GRAPHIC N°2

WAY IN WHICH THE SPECIAL WORKS MADE BY THE EVALUATION UNIT ARE FROM JANUARY 1 TO JUNE 30

STUDIES	Preliminary Design	Data Recolection	Data Elaboration	Data Tabulation	Data Presentation	Analysis	Reports	Impression	Publication
1	1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	1	-	-	-
3	1	1	1	1	1	1	2	2	2
4	1	1	1	1	1	1	1	1	1
5	1	1	1	1	1	1	1	1	1
6	1	1	1	1	1	1	1	1	1
7	1	1	1	1	1	1	1	1	1
8	1	1	1	1	1	1	1	1	1
9	1	1	1	1	1	1	2	2	2
10	1	1	1	-	1	1	2	2	2
11	1	-	-	-	1	-	1	1	1
12	1	-	-	-	-	-	1	-	-
13	1	1	1	1	1	-	-	-	-
14	1	1	1	-	-	-	1	-	-
15	1	1	1	1	1	1	1	1	1
16	1	-	-	-	-	-	-	-	-
17	1	-	-	-	-	-	-	-	-
18	1	1	1	1	1	1	1	1	1
19	2	2	2	2	2	2	2	2	2
20	2	2	2	2	2	2	-	-	-
21	2	2	2	-	-	-	-	-	-
22	2	2	2	2	2	-	-	-	-
23	2	-	-	-	-	-	-	-	-
24	2	2	2	2	2	2	2	2	2

2.- The Unit Director dictated conferences in the Social Workers Course in The Ministry of Welfare, also in Ambato and Riobamba Hospitals.

Very Cordially Yours,

Dr. Vladimir Basabe F.
EVALUATION UNIT
CHIEF

Copies: Dr. Wishik
Dr. Jaramillo
Mr. James

APPENDIX K

ARMED FORCES FAMILY WELFARE PROGRAM